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MULTICULTURAL HEALTH BROKERING: BRIDGING CULTURES TO ACHIEVE EQUITY OF ACCESS TO HEALTH

BY

LUCENIA M. ORTIZ

©

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in partial fulfillment of the requirements for the degree of

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The undersigned certify that they have read, recommended to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled MULTICULTURAL HEALTH BROKERING: BRIDGING CULTURES TO ACHIEVE EQUITY OF ACCESS TO HEALTH submitted by LUCENIA M. ORTIZ in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY.

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DEDICATION

This thesis is dedicated to all the multicultural health brokers who have wholeheartedly supported many families and are unceasingly serving their communities.

ABSTRACT

Clinical studies and ethnographic and qualitative studies showed that certain health and social services in Canada are not culturally sensitive to ethnic minority population. There is also evidence they have unique circumstances that predispose them to ill health. The practice of multicultural health brokering emerged as a community-level response in supporting ethnic minority individuals and families obtain equitable access to health services and health-promoting resources and opportunities.

The study aimed to capture the cultural brokering experience of the Multicultural Health Brokers (MCHBS) through the use of grounded theory analysis. This data served as the foundation to systematically describe and define the multicultural health brokering practice.

Using grounded theory and participatory action research, the study created a collaborative process of theory construction. Interviews and focus groups were conducted with fifteen (15) multicultural health brokers in Edmonton, Alberta, Canada. The research participants were actively engaged in organizing, analyzing, interpreting and analyzing their data to formulate a theory about their practice. The grounded theory on multicultural health brokering practice has four stages: initiation, building connectedness, brokering support and achieving equity of access to health. These stages describe how a multicultural health broker functions supporting ethnic minority individuals and families resolve their health and related issues. The multicultural health brokering practice is also multi-dimensional involving providing one-on-one support for individuals and families, building supportive groups, building community capacity for self-determination and catalyzing institutional change for cultural competence. These dimensions define the arenas where multicultural health brokers work to respond to

immediate needs and issues of individuals and families within their social and cultural context and also address underlying conditions and circumstances. Multicultural health brokering is aimed at achieving equity of access to health for individuals, families, groups and communities who have limited opportunities for responding to their health issues, maintaining and supporting their quality of life and well-being.

The multicultural health brokering practice is an example of an adaptive strategy within the human ecology framework. The practice supports ethnic minority newcomer to gain access to resources and opportunities that would increase their chances for successful settlement and integration in the new country.

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Part One
Introduction

Canada today has about five million foreign-born residents comprising nearly 13% of the country's total population (Statistics Canada, 2000). Canada welcomes an estimated 220,000 immigrants and refugees from more than 50 countries every year (Canadian Immigration and Citizenship, 1999). Immigrants from these countries bring their distinct cultural heritage, values and beliefs, making Canada today a diverse society. While enriching the country's demographic assets, this increasing diversity also illuminates the plurality and complexity of the needs and aspirations of its citizens. Health and well-being are central among those aspirations. As such, institutions mandated to provide services face a tremendous challenge when responding to the differing needs of a diverse Canadian population. In particular, the task of responding to diversity entails ensuring opportunities and resources for immigrants and refugees so that settlement and integration in a new environment becomes a healthy process. From a sociological perspective that takes into account the different needs of social groups (Restreppo, 2000), immigrants and refugees are a minority population in a largely Euro-Canadian society. Their access to society's resources such as education, employment, health and social services may be compromised by certain linguistic, social and economic circumstances.

The issue of equity of access to health care by an ethnic minority population provides the broad context of this study's research and is built upon the notion that "nurturing diversity must be viewed and shaped within the lens of equity and social justice" (Alleyne, 2000). The health of immigrants and refugees who constitute the ethnic minority population is multidimensional in character and has historical and political origins. The means to achieve equity of access to health for this population extends beyond the purview of biomedicine and the health care system. This study focuses on a practice called multicultural health brokering as one of the avenues by which ethnic minorities obtain health services and access health-promoting and health-supporting resources.

This introductory chapter will set the tone and context of the study by briefly describing immigrant and refugee health and the factors and conditions affecting their state of health and well-being. This broad context will help in understanding why the multicultural health brokering practice emerged through the work of a group of immigrant women in Edmonton, Alberta, Canada.

This chapter also includes the purpose of the study, background for the study, the theoretical frameworks that guided the conceptualization and conduct of the research and a review of literature relevant to the exploration of the multicultural health brokering practice.

I. Overview of the health of immigrants and refugees: Defining the issue of equity of access to health

For a long time, data on the health status of immigrants[1] and refugees[2] was scant and sporadic. The only comprehensive investigation done at the federal level was the report by the Canadian Task Force on the Mental Health Issues Affecting Immigrants and Refugees in 1988. This report elaborated on the mental health issues caused by settlement and the adaptational challenges experienced by immigrants and refugees (Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees., 1988). In 1999, Health Canada under the Metropolis Project completed an exhaustive scan of available studies, published and unpublished, on immigrant health. The findings in this report revealed a composite profile, though limited in explanatory details, of the status of immigrant and refugee health in the last two decades. Below is a summary of the salient findings in the report, *Canadian Research on Immigration and Health*, based on numerous studies on immigrant and refugee health collected by Health Canada (1999a):

- The report revealed a phenomenon called the "healthy immigrant effect", which describes the fact that immigrants are generally healthy upon arrival compared to native-born Canadians but lose this advantage over time. This

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[1] Immigrants – persons who have been granted permanent resident status to live in Canada. (CLEO Fact Sheet, 1999)

[2] Refugees – people with a well-founded fear of persecution in their home country or members of a designated class [those countries recognized by the Canadian government as oppressed in their home country or displaced by emergencies. (CLEO Fact Sheet, 1999)]

- can be explained by a stringent immigration screening process which disqualifies people with serious medical conditions. Studies cited in the aforementioned report have shown, however, that over time chronic conditions among immigrants match those of the Canadian-born population. For example, newcomers generally arrive with healthier behaviours. Studies show that smoking and alcohol consumption among immigrants increases with length of residence.
- Refugees have poorer health than immigrants, which is largely attributed to their pre-migration trauma experience as well as the less stringent selection process. Children in particular may experience long-term behavioural and social impacts of post-traumatic stress.
- Immigrants and refugees generally have lower utilization rates of health services such as use of hospitals, mental health services and specialist services.

It is interesting to note that even with a comprehensive scan by Health Canada on immigrant health, there are still conflicting findings about how immigrants and refugees are faring in terms of their health status. Using data from the 1985 and 1991 General Social Survey, Laroche (2000) concluded that there is no significant difference in the health status and utilization patterns of health services between immigrant and non-immigrant populations based on self-reported measures of health status. However, some studies noted with concern the use of self-assessment measures by culturally-diverse groups, particularly refugees because of their tendency to underestimate their health conditions (Health Canada, 1999a). Laroche's (2000) study also indicated that place of birth determined the number of consultations made by immigrants to health providers. Those who were foreign-born made fewer visits to health providers than the non-immigrant population. Possible reasons for this cited in the Laroche study may be the reticence of respondents when answering survey questions or even difficulties in accessing certain health care services. Several studies have documented linguistic and cultural barriers when immigrant and refugee populations obtain health services (Ballem, 1998; Blackford, Street, & Parsons, 1997; Cavé, Maharaj, Gibson, & Jackson, 1995; D'Avanzo, 1992).

This brief overview of immigrant and refugee health makes visible, even as we struggle to look for conclusive evidence, that immigrants and refugees who make up the majority of the ethnic minority population have unique circumstances that predispose

them to ill health. Halli and Kazemipur (1998) concluded that the pre- and post-migration experiences are factors that place immigrants and refugees at greater health risk than the general Canadian population. In Marmot and Wilkinson's (Dixon, 2000) comparative study across countries, it was suggested strongly that when people change social and cultural environments their susceptibility to disease and illness also changes. The following section will shed light into some of the significant factors and circumstances contributing to the health risks and vulnerability of immigrant and refugee populations, and how these factors influence equity of access to health by ethnic minorities.

The issue of equity of access to health by ethnic minorities

The concept of equity in the literature is broadly associated with the notion of being "just and fair" (Birch & Abelson, 1993; Calman, 1997; Daniels, 1982). This concept is distinct from equality, which means the "state of being equal or applying in the same way to all people or in all circumstances" (Collins Concise Dictionary & Thesaurus, 1995 , p.310). Equality implies that when equal rights are granted, everyone will have identical privileges, rights or status. Restreppo (2000) cited sociologists Kadth's and Tasca's definition of equity as "life opportunities, or life-chances" (p.7). According to Starfield (2000), equity is the "absence of systematic inequality across population groups" (p.1). The World Health Organization strongly advocated "equity in health" as its theme for the Fifth Ministerial Conference on Health Promotion in 2000. Equity in health is defined as "the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically" (International Society for Equity in Health, 2002). The concept of "equity in health" acknowledges the disparities in health status among populations and recognizes the role of society in addressing these differences through government policies and programs (Alleyne, 2000). Calman (1997) situates equity in health to imply "that everyone should have an opportunity to attain their full potential for health, noting that variations and inequalities among populations may be unavoidable" (p.2). These differences may originate from natural, biological and genetic variations as well as economic and social disparities created by political and

historical conditions. Equity has two dimensions: equality, which means the availability of opportunities to everyone to achieve their human potential without barriers. The other is that of distributive justice, which implies that positive steps must be taken to compensate for various social and natural variations between people which may arguably confer "unfair (ness)" (Daniels, 1982). In other words, equity in health implies a moral and ethical responsibility to increase chances or opportunities for sustaining the health and well-being of certain individuals and populations who would not have the same chances as everyone else (Restreppo, 2000).

Access refers to the conditions for allowing entry into a place or the right or opportunity to use something (Collins Concise Dictionary & Thesaurus, 1995). Access to health can be defined according to the physical proximity of health services (geographic), cost of health care and other social supports (economic), or the appropriateness of the health service and other social programs that support health (cultural) (Jourdain, 2000). Access to health refers to conditions that enable individuals and population groups to use resources and opportunities to address a health need or an issue as well as to support and maintain health. Measuring equity of access to health has been traditionally focused on the utilization rates of health care services. Daniels (1982) posits that a true measure of access goes beyond the point of contact (when an individual enters the formal health system) but also looks at the "humaneness of care" delivered. This implies including subjective measures of satisfaction and the client's perception of a positive health experience. Beyond individual measures, a profound criterion of equity of access to health must originate at the macro level of availability and distribution of community resources that influence health and well-being (Aday, 1993). Equity of access to health therefore implies that all people will have equal opportunities to develop and maintain their health through a fair distribution of these resources (Ziglio, Hagard, McMahon, Harvey, & Levin, 2000). The following section presents the challenges that confront ethnic minority populations in achieving equity of access to health and in fulfilling their aspirations for a better life in the new country. These challenges include the relationship of social inequality, poverty and health; the impacts of immigration and multiculturalism policies and institutional disincentives to accessing health services by ethnic minority populations.

Social inequality and poverty of ethnic minorities

Wilkinson's (1996) studies on inequality among countries using poverty measures and mortality rates have provided strong evidence about the relationship between income inequality and poor health. Egalitarian countries, regardless of their nation's wealth, have healthier citizens in terms of longer life expectancies and lower death rates than countries who are wealthier but that have the widest income differences among the population (Wilkinson, 1996). In their latest book, *Social Determinants of Health*, Marmot and Wilkinson (Dixon, 2000) argued that differences in health between population groups are largely due to the characteristics of society and not necessarily to differences in health care systems. They contend that poverty becomes a powerful determinant of health when it occurs significantly with a social hierarchy, which means that as one moves down the social hierarchy health status also declines. Wilkinson (2002) believes that the psychosocial effects of social relations such as low self-esteem and isolation can offer a more plausible explanation of health outcomes and the cited impacts of racial discrimination as an example (Dixon, 2000). Following this argument, health risks and related health outcomes have social-structural origins and are associated with varying access to social and economic resources determined by age, gender, race and social class (Tesh, 1988).

The inequality of Canadian society is documented by comparing the Social Health Index and the country's Gross Domestic Product. The Social Health Index is a composite picture of a nation's well-being representing the aggregate quality of life of its citizens drawn by 15 indicators [3](Stephens, 1998). Gross domestic product or GDP is the total value of all goods and services produced by a country and this represents a country's estimate of its wealth. According to Human Resources Development Canada (HRDC), there has been a sharp divergence between the GDP and the Social Health Index since 1980 and this continues to widen (Stephens, 1998). This divergence implies that the growing wealth of the country does not manifest itself in the improvement of people's lives; this wealth is inequitably distributed and so the distribution of ill health

---

[3] Social Health Index indicators include infant mortality rates, child abuse, child poverty, teen suicides, high school drop-out, adult employment, senior's poverty rate, income inequity, housing, health costs and average weekly earnings.

following Wilkinson's (2002) argument on inequality and health. This image of Canadian society is further described by John Porter as a "vertical mosaic", portraying the social hierarchy defined by class, ethnicity, language and religion (Lautard & Guppy, 1999). It is a social structure of class and privilege that favours the Caucasian, English-speaking majority population in positions of social mobility and economic advancement (Clement, 1999). Reza Nakhaie (1999) reviewed the ethnic composition of power circles in Canada – politics, business and the bureaucracy. While ethnic homogeneity is gradually diminishing, British dominance is still very visible in all avenues of power (Clement, 1999) including the media, and continues to demonstrate a "marked persistence" of "like recruiting in all of the Canadian dominant institutions" (Nakhaie, 1999, p.275). This societal context helps to frame the issue of equity of access to health and extends an understanding of this issue beyond specific and easily-identifiable factors and circumstances that determine how individuals and population groups are able (or unable) to use resources and opportunities for health.

Rising poverty contributes to the growing inegalitarian social structure in Canada. According to Halli (1998), poverty may be absorbed more by certain segments of the population, and one such segment will most likely be the ethnic minority population. Lee (2000) compiled urban poverty profiles across cities in Canada and concluded that the overall poverty rate of immigrants is 30%, which is higher than those of the Canadian born-population at 21.6%. Within the immigrant population, newcomers, especially those coming from Third World countries, and visible minorities have lower incomes than those coming from developed countries (Health Canada, 1999a).

In general, poverty among recent immigrants declines as the length of residence increases. However, in a study among immigrants who arrived in 1980, it is estimated that it will take them 10-14 years of residence before their earnings could equal or surpass a Canadian-born's earnings (Health Canada, 1999a). Furthermore, recent trends in the data of tax filers from1982 -1994 indicate decreasing incomes and a growing gap in earnings between immigrants and the Canadian-born population (Lee, 2000). Neuwirth and De Vries suggest that this trend may be leading to a new "underclass" in Canadian society (Health Canada, 1999a). Studies have shown that this emerging

"underclass" will most likely be immigrants in poor neighbourhoods and the effects of poverty will be persistent, extending over generations (Halli & Kazemipur, 1998).

Impact of immigration and multiculturalism policies to ethnic minority health

The social origins of the health risks and health outcomes presented earlier imply that a discussion of ethnic minority health falls within the realm of public policy. Policies on immigration and multiculturalism will be discussed in this section to explain why they affect the health and well-being of immigrants and refugees.

"Immigration policy is the single most important factor in determining the size and composition of ethnic communities" (Li, 1999 , p.16). Canadian immigration policies had evolved from the nationality-preference system that favoured European countries as sources of immigrants to the Chinese Head Tax that levied exorbitant fees on Chinese immigrants from 1855 to 1945, and then to the current Points System, which emphasizes economic criteria. Immigration policies have become a tool for unequal social status and position when preferential treatment, such as less stringent entry requirements is given to charter groups over other ethnic groups.

Despite the existence of public policies purportedly meant to uphold the rights, freedom, equality, equity and respect amongst all people in Canadian society, these policies have not been able to address and eliminate racial inequality. Henry and Tator (1999) tell us how the execution of three major state policies have diminished the legitimacy of these policies and compounded the impact of racial bias and discrimination.

The Canadian Charter of Rights and Freedom of 1982. This legislation was considered to be a historic triumph for ethnic minorities. For the first time, racial discrimination became unconstitutional. But critics claim that flaws in this legislation perpetuate further status inequalities rather than addressing racial discrimination (Parhar, 1999). Henry and Tator (1999) assert that the legislation lacks clarity in defining discrimination, racism or race. It is a passive rather than an active tool for promoting racial equality, and it lacks adequate support for victims of racism and discrimination.

Employment Equity Act of 1986. The purpose of this Act was to achieve equality in the workplace and to redress the conditions of disadvantage of employment experienced by

designated groups: women, Aboriginals, persons with disabilities and visible minorities. The Canadian Human Rights Commission reported on the government's dismal record of promoting minorities in the public service despite its rhetoric of embracing diversity. For example, visible minorities make up 4.5% of government employment, which is not even half of all visible minorities, which constitute 13% of the total population (Henry & Tator, 1999). Other studies revealed the lower earning differentials of visible minorities compared to similarly-qualified white males (Swidinsky, 1997), and higher job prospects for whites than blacks in Canada (Henry & Tator, 1999) .

Employment equity has been cited as one of the crucial factors influencing immigrant and refugee health in the report, *Canadian Research on Immigrant Health.* "Racial discrimination in the labour market is so pervasive and especially harmful to a new racial minority who face compound obstacles" (Health Canada, 1999a , p.31). The devaluation of foreign credentials and work experience is perhaps one of the most significant and interminable discriminatory practices painful to most immigrants and refugees. It has shown to be a persistent barrier to gainful and meaningful employment. Although employed, despite their higher education many immigrants have lower occupational status and income attainment than most native-born Canadians (Parhar, 1999). Roughly four out of ten immigrants above 15 years old are university educated (Coultier, 1999) yet they are over-represented in the service sectors working as food servers, taxi cab drivers, hotel workers etc. (Basavarajappa & Jones, 1999; Taffesse, 1999).

Employment inequities may be the greatest barrier to the mobility and advancement of ethnic minorities in Canada. It could be the single most important determinant to their health and well-being because newcomers depend entirely on their personal resources - skills, education and work experience to enter into the labour market and provide the basis for their economic and social security. If the search for economic stability becomes insurmountable and fraught with difficulties, it has an acute and deep impact on personal and family health (Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees., 1988).

The Canadian Multiculturalism Act of 1988. This Act, which was created to preserve the language and heritage of all ethnic groups, is criticized as "symbolic ethnicity" (Lance & Clifton, 1999). While the Act supports heritage celebrations, it does little to dismantle

systems of inequality and diminish hegemonic white power and privilege (Henry & Tator, 1999). Henry and Tator (1999) and Parhar (1999) extensively documented how racism pervades law enforcement agencies, the justice system, government, education, media, human services and the arts. Furthermore, they argued that the state's activities within the framework of the Multiculturalism Act can neither eliminate nor control racial discrimination because the legacy of racism is so embedded in the collective culture of the majority group.

Institutional disincentives to accessing health services

Further compounding the societal factors that contribute to increasing health risks in ethnic minorities are barriers towards obtaining health services .There is a strong perception, based mainly on clinical studies and ethnographic and qualitative studies, that certain health and social services in Canada are not culturally sensitive to immigrants and refugees and their needs (Masi, Mensah, & McCleod, 1999). Here is the personal account of one social worker:

> I was trying to set-up a medical appointment for a client of mine. When I first asked if the doctor was taking on new patients, the secretary gave me the impression they were. But when the secretary requested the name of the patient and I gave her one that could be easily identified as being from another culture, I was quickly dismissed - I was told that the doctor would not be taking any new patients. This sort of things happens on a regular basis. Some of the other services that I have not been able to access for my clients are: psychiatric care, dental care, counselling services, prenatal care and even social assistance.
>
> Janet Mackey, Social and Settlement Worker
> Newfoundland and Labrador
> *(Mackey & Baron, 1997-1998 , p. 12)*

In a mental health care study in Montreal among six ethnic groups, of all stated reasons for not seeking help from a mental health professional, ethnic mismatch had the highest value on a factor analysis of four other reasons. Ethnic mismatch was reflected in these three statements (Kirkmayer, du Fort, Young, Weinfled, & Lasry, 1996 , p.69):

> I felt there would be prejudice or racism against me.
>
> Professionals from my own cultural or ethnic group were not available.
>
> I felt that my culture or ethnic background would not be understood.

The complexities of a health care system many immigrants and refugees find unfamiliar stand as a major disincentive towards access and utilization. Navigating the various services in a hospital is already a challenging task for a newcomer who speaks very little English who may then find himself/herself treated rudely or denied services (Mackey & Baron, 1997-1998). From the point of view of health care providers, language competence is the biggest issue in providing quality health services (Young, Spitzer, & Pang, 1999) Furthermore, service providers lack cultural knowledge that could enhance the interaction between immigrant clients and native-born professionals (Health Canada, 1999a). Change is most often a slow process in institutions such as the health care system. Freedman (1999) contended that health institutions are still governed by a traditional biomedical and ethnocentric approach to program development and service delivery, and they lack the temerity to adapt to the emerging needs of a culturally-diverse population. So far, there is no evidence across Canada of clear, consistent and conscious commitment to institute deep, thoroughgoing and transformative organizational changes in this area.

Within this broad context of ethnic minority health, the practice of multicultural health brokering emerged as a community-level response to support ethnic minority individuals and families seeking to obtain equitable access to health services and health-promoting resources and opportunities. The current practice of the Multicultural Health Brokers (MCHBs) has been largely guided by praxis and experiential knowledge created from their work in ethnic minority communities. The idea of developing a conceptual model to synthesize their eight-year practice appealed to the MCHBs as they sought greater clarity of their work and their role in improving access of the ethnic minority population to health-promoting and health-enhancing resources. This research sought to fulfill the need for developing a model that involves describing the collective experiences of MCHBs and advancing this knowledge to the level of a theory.

II. Purpose of the study

The purpose of the study was to capture the cultural brokering experience of the Multicultural Health Brokers (MCHBs) through the use of grounded theory analysis.

This data served as a foundation to systematically describe and define the multicultural health brokering practice. This research was more than an investigation into many facets of the multicultural health brokering practice. The research question embodied the MCHBs' individual and collective aspirations as practitioners and as an organization. For the MCHBs, this study was a journey into discovering their individual strengths and limitations in relation to providing the best quality of care to ethnic minority women and their families. It was a search for the best ways to support and strengthen each other while dealing with the most difficult circumstances of their clients, their communities and their own personal situations. Finally, for the Multicultural Health Brokers Co-op it was part of a collective undertaking of building an organization whose ideology of caring resonates with the ideals of transformative change, democratic participation and a commitment to equity and social justice.

III. Background of the study

This section will describe the setting where the multicultural health brokering practice emerged, a history of how the practice began and flourished and how the multicultural health brokers identified this study as a need.

The Setting: Edmonton, Alberta, Canada

Edmonton is the fifth ethnically-diverse city in Canada. Of the city's population of 927,000, visible minorities constitute 15 %, most of whom are immigrants and refugees (Statistics Canada, 2003) . In 2001, Edmonton ranked sixth among the top ten cities of destination for immigrants and refugees (Citizenship and Immigration, 2001). Using mother tongue as a proximate indicator of ethnicity, the city has about 21 ethnic groups (Statistics Canada, 1996). In a spatial concentration study of poverty (SCOP) among immigrants in 1998 among the six cities, Edmonton and Winnipeg were found to experience, over the last ten years, an increase in the number of poor families in high-poverty neighbourhoods (Halli & Kazemipur, 1998). High-poverty areas are defined as neighbourhoods within census metropolitan areas (CMA) with more than 40% of families below the Low Income Cut-Off (LICO) (Halli & Kazemipur, 1998). These

neighbourhoods also have a high concentration of visible minority immigrants composed of West Asians, South Asians, Latin Americans, Chinese, Filipino, Vietnamese, Arab and Blacks. The same study found that Edmonton and Toronto have the highest correlation coefficients between the poverty of neighborhoods and proportion of immigrants amongst major cities in Canada. In a 40-city study of poverty among immigrants, Edmonton ranked 12th with a poverty rate of 30.1% (Lee, 2000).

In a recent study on the health care needs of immigrants among three ethnic groups in Edmonton, the respondents identified the following barriers to health (Young et al., 1999):

- Economic, such as financial stress due to underemployment and lower income, poor living conditions and overwork;
- Social problems, particularly racism and discrimination in schools as well as the lack of a social support network; and
- Specific health care issues relating to unfamiliarity with the health care system, cultural misunderstanding between clients and health care providers and inflexibility of the medical regimen with regard to treatment plans.

History of the Multicultural Health Brokers (MCHBs)

Multicultural health brokering evolved out of the work of a group of immigrant women in 1992 when they were recruited from their communities and trained in perinatal health education by the Edmonton Board of Health. The health department was concerned that ethnic minority women were not accessing their prenatal programs. At that time, these immigrant women called themselves *multicultural childbirth educators,* and delivered perinatal health information to pregnant immigrant women in their own language while blending western medicine with traditional birthing practices. Their work was funded by Health Canada for three years. Many pregnant women were newcomers to this country. As they worked closely with the women, the multicultural childbirth educators became involved in deeper issues of poverty, loss of support, hopelessness and isolation. They began to connect with service providers and institutions to help families obtain the services and resources that they needed. They also looked to the community to provide the social support the women longed for.

Because of this expanded role, the childbirth educators changed their name to *multicultural health developers* to reflect their community development functions. An article by Weidman (1982) on cultural brokerage that described the role of cultural brokers in a mental health project in an ethnically-diverse community caught the attention of the multicultural health developers. In this project, the cultural brokers were people familiar with the community and who mediated between community members and mental health service providers responding to mental health issues, while also addressing community issues impacting mental health. Inspired by the cultural brokers in this project, the multicultural health developers dropped the term "developer" and adopted the word "broker". In 1998, they officially changed their name to multicultural health brokers and called their work multicultural health brokering.

Multicultural means that the arena of their work is with and for ethnically- and culturally-diverse communities. Health, from the multicultural health brokers' perspective, means a broad definition beyond the absence of illness and disease to an overall state of well-being and quality of life as well as a resource for everyday living. Their (MCHBs) beliefs about health embrace both western biomedicine and indigenous traditions of healing and wellness. The multicultural health brokers offer a holistic and family-oriented practice that extends beyond responding to present and immediate issues, but also in being attentive to the underlying factors that determine health. Brokering collectively describes a wide range of services provided to individuals and families such as bridging cultural understanding, providing support to individuals, families and communities and linking them to resources to overcome their difficult life circumstances (Sykes, Wolfe, Gendreau, & Workman, May,1997.). Over the years multicultural health brokering has flourished in Edmonton as ethnic communities became increasingly diverse and disadvantaged (seeGalabuzi, 2001) and social supports in the formal system continued to diminish.

In 1998, the Multicultural Health Brokers Cooperative, perhaps the first of its kind in Canada, was organized. It marked the formalization of the MCHBs as an organized group that promoted a culturally-competent practice as well as harnessing the inherent capacities of ethnic minority populations. The mandate of the Co-op is to

"support immigrant and refugee individuals and families in attaining optimum health through health education, community development and advocacy support" (Multicultural Health Broker's Coop, 1998). The guiding principles of the Co-op are democratic governance, responsiveness, accountability, equity and social justice. This set of principles reflects a deep and profound understanding of health that encompasses personal health and its collective context. In particular, the Co-op recognizes that ethnic minority populations are inherently disadvantaged in a stratified society like Canada. Health, when viewed from this perspective, dictates that interventions be framed within the principles of addressing inequities and balancing power structures. The MCHBs Co-op lays the formal basis for organizing and consolidating the collective work of the MCHBs. It offers a venue for mutual support amongst MCHBs while they work at the edges between two cultures. Moreover, the MCHB Co-op crystallizes an expression of solidarity when advocating for meaningful changes in promoting the health and well-being of ethnic minority populations.

My discussions with the MCHBs prior to this research revolved around the need to strengthen their practices. In particular, cultural brokering as experienced by immigrant women in Edmonton needs a coherent framework grounded in the MCHBs' own experience and understanding of the work. The demands of their role and tasks over the years have overtaken them, leaving little time for personal and collective reflection. The extent and outcomes of the support they have provided to women, their families and community groups need to be defined and determined to establish the efficacy of their service and its impact on transforming the nature of health service delivery for culturally-diverse groups. The breadth and depth of their relationships with clients, community groups and health providers need to be exhaustively explored to describe a collaborative practice that would be crucial to a genuine health-promoting and health-enhancing process.

This is how this research came to be. The research is meant to be an opportunity for the MCHBs to begin a process of learning and reflection as a basis for improving their practice and for creating meaningful changes in their communities.

IV. Theoretical frameworks guiding the research

This study of multicultural health brokering is directed at theory development rather than theory testing or verification. The study did not attempt to operationalize concepts and relationships based on an existing theory, but rather generated data that is the basis of an emerging theory, in this case multicultural health brokering. Blumer, as cited by Chenitz (1986), notes that the entire research act is shaped and influenced by the researcher's view of the world. The general area or field of study, the kinds of research question/s, the methodological orientation and the direction of the analysis is an expression of the researcher's philosophy, values and beliefs. In this research, I chose several theoretical frameworks that articulate what I value and believe. These frameworks refer to the human ecology theory, critical social science perspective and a conceptual tool called the cultural frame. These all serve as the conceptual lenses for how this study will be framed and conducted. A review of key concepts will initiate a discussion of the theoretical frameworks to familiarize the reader on the terms that will be used throughout this dissertation. These concepts are ethnicity, race and health.

Ethnicity, race and health: A review of concepts

Ethnicity

Ethnicity conveys a notion of people with a shared heritage that forms the basis of their identity. This identity revolves around ethnic members sharing "a sense of peoplehood and identity based on descent, language, religion, beliefs, tradition and other common experiences" (Weber, 1968p.388). This identity, according to Weber (1968), provides the basis to "build closures or boundaries within which ethnic institutions, neighborhoods, beliefs and cultures are developed and maintained" (p.388). Smaje (1996) suggested that our knowledge about ethnicity should not be confined to the existence of ethnic categories, but also about "how these boundaries came to be constructed in particular historical, social and political circumstances and the consequence of these for social life" (p.142). What Smaje meant is that ethnicity also defines the status of ethnic groups within larger society. Phinney (1996), citing several

studies on minority experiences particularly ethnic groups of colour, speaks of lower status in leadership and authority, unequal social and economic positions as well as experiences of prejudice and discrimination.

Race

While the concept of race is still widely debated in literature, there is a general agreement that it is a "social construct" defined by a particular society (King & Williams, 1996). Although superficial physical differences may be associated with racial categories, skin colour being the most significant, scientific evidence shows that phenotypes (common visible characteristics) do not have corresponding genetic typologies (King & Williams, 1996). Li (1999), however, cautioned that the denial of race as a genetic or biological concept does not preclude the history of oppression and the common marginalization of groups identified as racial groups. King and Williams (1996) referred to the historical experience of slavery of African-Americans as illustrative of "racial classifications or taxonomies in American society (that) evolved from a system of stratification, power and ideology" (p.101).

Li (1999) suggested that race and ethnicity should remain in the discourse of social relations because "racial oppression still exists and remains a social fact in people's lives" (p.9). These concepts are "the product of historical processes which structure relations of inequality between discreet social entities" (Smaje, 1996 , p.142). Race and ethnicity are inextricably linked with the formulation of a majority-minority population model of racial group dominance and subordination. The majority is defined as a group that "uses power to control vital institutions and processes to maintain the status quo" (King & Williams, 1996,p.94), often identified as the white majority in North American society. The minority group is that which "regardless of size is, distinguishable on the basis of color, language, culture, sex, religion, or other recognizable features" (King & Williams, 1996,p.94). The minority is seen as consisting of those who have less power and influence over societal decision-making and who have unequal access to opportunity, structures, social rewards and status (economic, political, social and health status) (King & Williams, 1996). These inequities, whether intentional or unintentional, are most often systemic and invisible. Because of this, health issues among ethnic

minority groups across the continuum of health promotion, including disease prevention and treatment, cannot be approached in a social vacuum. Rather, they should be explained within the broader context of racial and ethnic inequities.

Health

The concept of health has experienced its own evolution, reflecting changes in the dominant discourse and theories of knowledge development. For the last two centuries, biomedicine has dominated the definition of health, revolving around the notion of *absence of disease, illness and disability* (Labonte, 1993). Health's roots could be traced to early theories of disease causation in the early 16th century, when scientific knowledge about anatomy, physiology and other biological aspects of the human body were discovered. The biomedical perspective remained preponderant in Eurocentric industrial societies and became the dominant discourse in creating knowledge about health and illness (Labonte, 1993; Rootman & Raeburn, 1994). The emphasis on disease and illness evokes a negative concept of health and reveals a weak philosophical underpinning when health is defined by what is it not rather than what it is. As such, the focus is on intervening at the onset of a disease or illness rather than finding ways to promote or enhance health. In 1947, the World Health Organization redefined health as "the complete state of physical, social and emotional well-being and not merely the absence of disease and infirmity" (Health Canada, 1999b). This definition incorporated a positive and holistic approach to health that significantly stimulated the growth of multiple interpretations of the concept (Rootman & Raeburn, 1994).

The relationship of ethnicity, race and health has been continuously explored in the biomedical world and the social sciences. Whether an epidemiological or anthropological approach to research was used, the evidence of distinctive health patterns such as mortality and morbidity, utilization of services, help-seeking behaviour etc. among ethnic groups has been widely documented (Health Canada, 1999a; Nasroo, 1998). There are differing analyses of what determines the differential patterning of health. There are those who argue that it could be explained on the grounds of socio-economic advantages or cultural variations, as in the Black report from the United Kingdom (Townsend & Davidon, 1992). On the other hand, social scientists in the

United States studying the relationship between race and health in American society are "confronted with a powerful historical legacy of social stratification, discrimination and oppression based on phenotypic characteristics such as skin color" (King & Williams, 1996,p.101). Also, the dismal status of Aboriginal health in Canada as a consequence of the historical and political oppression of First Nations people is illustrative of how ethnicity, race and health are powerfully interconnected and complex (Waldram, Herring, & Kue Young, 1995). Thus, Longos (2000) admonished those who are in the health sector, whether a practitioner or from academia, that a critical omission to exclude race and ethnicity in any discussion about health will risk eliminating the larger contextual issues that impact health, illness and patient care.

Theoretical frameworks

The holistic nature of multicultural health brokering and the complexity of ethnic minority health issues require a wide range of disciplines from which to draw theories to guide and shape this research. The selection of theoretical frameworks cannot be limited to one single discipline, nor to any particular way of knowing. Thus, the search for theoretical frameworks focus on a conceptual breadth (how the concept articulates a holistic and integrated approach in understanding and constructing reality), relevance (how the concept relates and gives meaning to what we currently know about multicultural health brokering) and lastly, an ideological stance (how the framework supports progressive and transformative change). The theoretical frameworks presented in this study serve both as a paradigmatic orientation and a conceptual underpinning in the conduct of the research. The human ecology framework provides the overarching discipline that helps to frame the concept of health from a broad environmental context. The critical social science perspective, whose roots are in critical theory, is used as a theoretical tool to ensure sensitivity of the research when unravelling issues of power and inequity. The cultural frame is an applied conceptual tool for exploring the holistic nature of the multicultural health brokering practice at the level of the individual health experience. These frameworks also collectively define the relationship of the researcher and participants, the method of data collection, the scope of data analysis and interpretation, and the envisioned outcomes of the study.

Human ecology and the critical social science perspective in health

The relationship of people and their environment has always fascinated thinkers and scientists to the extent that an entire science was created out of it. The term ecology was first introduced in 1869 when Haeckel defined it as "the study of the interrelationship between organisms of life and the environment, both organic and inorganic" (Bubolz & Sontag, 1993, p.419). Understandably, ecology drew heavily from the physical and biological sciences to explain events and processes occurring in the environment. In the early 1900s, Bews (1935) extended the concept of ecology to a philosophical perspective. He stated that ecology is more than a body of scientific knowledge, it is also "a certain attitude of mind with regards to life" (p.1), such that ecology is as much a comprehensive viewpoint about the ultimate reality of life and nature as it is a method of science. Construction of reality is undoubtedly a human experience beyond the realm of physical and biological disciplines. The concept of human ecology derives its origins from the persistent search to explain how people create and react to their environment. Survival, quality of life and sustaining the environment are ways to achieve adaptation – a key process in human ecology (Bubolz and Sontag, 1993). Undoubtedly, survival and quality of life are also central concerns in human health.

Improvements in health in the last millennium have not all been credited to advances in medical science. Last (1998) concludes, "ecologic factors account for past changes (in health) and will be responsible for future changes" (Last, 1998 , p.28). These factors include changes in the social environment, growth of cities, rise of automated technologies, overwhelming influence of mass media and changes in patterns of housing, lifestyles, etc. All of these factors share a profound influence in human health. Human ecology, as a "body of knowledge which is concerned with the relationships that humans have with the environment" (Polk, 1995 , p.4), is a logical organizing framework for understanding the interaction of broad societal factors that determine health and illness. Cohen-Rosenthal (2000) stated it succinctly when he noted how the ecological principles of "whole system thinking, recycling of resources and energy, conservation, diversity, multifunctionality, interdependence, resilience and adaptation" are all

important principles in the area of health whose goal is nurturing life (p.3). Human ecology, then, is an eclectic discipline drawing from a wide range of physical, biological and social theories. Last (1998), in his advice to young students in public health, introduced a definition of health from a human ecological perspective: "Health is a sustainable state of harmony among humans and other living things in which we share the earth" (Last, 1998 , p.430).

Hancock's (1993) ecological model of health, human and community development is an attempt to apply a human ecological framework to macro-factors such as economic growth and micro-factors such as community dynamics in explaining health and illness. Key ecological concepts are integrated in Hancock's model, such as (Bubolz & Sontag, 1993):

- The human ecosystem which consists of essential qualities and tasks of individuals and the pursuit of normative development.
- The environment includes the individual's internal physiological, mental and intellectual processes and the external environment, which encompasses their immediate surroundings and the community and society in which they live and relate.
- The human-environment interaction involves the process of adaptation and survival as well as sustaining the environment for continuing support and maintenance of quality of life and well-being.

Hancock's model, according to Collins (1995) , was an explicit attempt to introduce the concept of sustainability of economic and environmental practices in discussions about health. Hancock's model centered on three key elements: social support and public participation, developing an economy that is both socially and environmentally sustainable and a viable and built environment (Hancock, 1993).

Collins (1995) took this model further to develop a nested model of health where individual determinants of personal health are "nested" within a larger model of community determinants. This model shares Bronfenbrenner's model of nested environments, wherein environmental contexts are embedded within layers of environments arranged in concentric circles (Bronfenbrenner, 1979). The ecological models allow us to look beyond the medical and biological explanations of health and

extend our perspective to community and societal factors collectively known as the determinants of health. The Canadian Institute of Advanced Research developed a framework for the determinants of health to illustrate the interaction of broad environmental factors with health and illness (Mustard & Frank, 1991). With the recognition of the determinants of health, the concept of health has advanced from a unidimensional concept of disease and illness to a multi-faceted and complex web of interrelated economic, social, cultural and environmental factors that influence any person's state of well-being. This view of health articulates the WHO definition of health that encompasses the physical, social and emotional dimensions of human well-being.

Although these ecological models widened the arena for discussing the determinants of health, these models did not challenge the issue of power structures including class in society, and their compelling influence on the incidence and distribution of disease and promotion (or non-promotion) of health (McKinlay, 1994; Eakin, Robertson, Poland, , & Edwards, 1996). Relying solely on the discipline of health and medical sciences would not be adequate to capture and deepen our understanding of the impact of power structures on human health. This requires exploring how other disciplines such as sociology, anthropology or political science can explain the complex interaction of the environment and human behaviour and how this interaction is impacting the health of individuals and populations.

Human ecology as a discipline allows the freedom to choose from among the varied ways of seeking and creating knowledge, not limiting ourselves to what is dominant and acceptable but to explore where reality or truths can be relevant and meaningful to those who must use this knowledge. Human ecology as an integrative discipline allows this study to expand the understanding of health and its determinants and to adopt methods of knowing that usher in the discovery of aspects of society that are oppressive and inegalitarian. One example of such methods is the work of Habermas, a critical theorist, which is instructive in identifying a process of knowledge development that has emancipatory and transformative goals (Rasmussen, 1996). Known as critical science, this body of knowledge is a tool for action grounded on reason and historical experience (emancipative rationality), with the aim of freeing

individuals and groups from dominant ideologies of oppression (Bubolz, 1995; Rasmussen, 1996). Critical science grew out of the ideas of a group of German scholars known as the Frankfurt School, which first espoused critical theory. The basic premises of critical science are the contextual nature of reality (and perhaps to some extent the nature of a 'truth'), a value-laden inquiry that directs the resulting knowledge and a purposeful effort to position the knowledge-seeking process towards emancipation from structures of domination (Bubolz, 1995). The role of knowledge is essential in critical science, where the fundamental question is "knowledge for what?" The function of knowledge within a critical science perspective is beyond discovering and describing "what is". To Bubolz (1995), knowledge should make us more "aware of ourselves (self-reflection) and others, to be enlightened about the injustice and oppression around us, to be emancipated and bring about desirable change of what should be" (p.3).

Freedman (1999) acknowledged the role of critical science in deepening the discussion of health. She emphasizes that the western biomedical view of health and the social policies derived from them are so deep and pervasive that their impact and operation can be difficult to recognize and even harder to contest. Critical theory introduces the dialectical process of action and reflection as a means of achieving higher levels of awareness and learning ("critical consciousness"). A critical theory is deliberate in challenging dominant ideologies by uncovering the interests, assumptions and values behind them (Bubolz, 1995). Critical theory has three major themes in the exploration of knowledge: interpretation of the meanings of social life; unveiling of historical problems of domination, oppression, alienation and social struggles; and a critique of society and ways to transform it (Creswell, 1998). Using the family as the focus of study, Bubolz (1995) contended that we must be *critical* (emphasis mine) to understand and explain the interdependence of family behaviour at different levels of its environment systems, and *emancipatory* (emphasis mine) to achieve desired changes and transformative outcomes.

The critical social science perspective (CSSP), whose roots are in critical theory, was built on the critical paradigm of inquiry that originated in the works of Freire (1973, 1990), Illich (1977), McKnight (1977, 1987), Alinsky (1971) and other social activists and

critical educators (Eakin et al., 1996). CSSP is based on "critical pedagogy" that engages the participants in a reflexive examination of the nature of social organization and the root causes of health (Poland, 1996). It assumes that knowledge is embedded within a set of power relations such that the process of inquiry is a continuous chain of posing questions to arrive at the root causes in order to analyze their implications and to take action for change directed towards equality and social justice. The emancipatory outcome is vital in the critical paradigm and is primarily concerned with creating more equitable structures of social relationships (Labonte, 1993).

Within the critical social science perspective (CSSP), conceptualizing health begins at the level of individual experience and behaviour and makes explicit its relationship to the broader societal, economic and political context. CSSP positions the determinants of health as embedded within the larger whole (political economy, culture, class structure, gender systems) and this broader context renders each determinant its character and shapes its relationships with other determinants (Amick III, Levine, Tarlov, & Walsh, 1995). The core features of the CSSP are profoundly relevant in the study of culture in health (Eakin et al., 1996). First, CSSP makes visible power issues at the individual, interpersonal and structural levels. For example, culturally defined gender roles and relationships or else systemic racism are all important when understanding the context of health issues among ethnic minorities. Second, CSSP opens opportunities for seeing things that could be otherwise and paves the way for potential change. For example, health as seen through a cultural lens enables service providers to be more sensitive to differences and inequities and thus can provide care and support in culturally appropriate ways. Third, it acknowledges that contradiction and dissension are essential to learning and change. Recognizing the plurality of cultures when interpreting a health experience is an arena where conflict and difference can be viewed as resources and opportunities for learning new ways of doing things rather than regarding them as problems. Fourth, CSSP articulates the dialectic relationship between individual experience and broad societal forces, where each one can influence the other. In the arena of multicultural health, while the individual or collective health experience is shaped by the cultural systems this does not preclude

people's ability to challenge the cultural system and make changes once this system becomes oppressive and harmful to their health.

The reflexive posture and transformative character of the critical social science perspective blend well in the study of power and diversity issues. For example, the role of power is manifested in the relationship between aboriginal and ethnic minorities and the Caucasian mainstream population. This power relation is profoundly expressed in inequities in the health status of ethnic minorities. The process of critical and participatory knowledge creation enables disempowered individuals and groups to gain equal status when constructing their own reality or concept of health. Knowledge seeking is pursued as a step to action taking - a process where people can collectively gain control of their own health and their own lives.

Human ecology theories provide an overarching framework for the exploration and inquiry of the multicultural health brokering practice. As an integrative discipline that draws its knowledge base from many disciplines, human ecology supported this study in situating the work of the MCHBs within a broader context. Human ecology also embraces diverse ways of knowing and allows knowledge-creating processes that recognize both experiential realities as well as scientific truths (Bubolz & Sontag, 1993). This study incorporated a critical social science perspective (Eakin et al., 1996) when conceptualizing health; it comes from the critical theory espoused by human ecology theorists such as Bubolz and Polk. In this research, multicultural health brokering is positioned against a background of marginalization and disadvantage wherein ethnicity and race provide what Longos (2000) called the broader contextual issues that impact on health and illness. The determinants of ethnic minority health earlier presented in this study reveal social inequities relating to the limited access of immigrants and refugees to societal resources that would increase their life chances and prospects in a new environment. This research sought to make issues of power and inequity visible when identifying the challenges confronting the practice of multicultural health brokering. The study has explicitly articulated how this practice can relate to the larger issues of advocating culturally responsive policies, programs and services. The emancipatory goal of the critical social science perspective underlies the researcher's and the

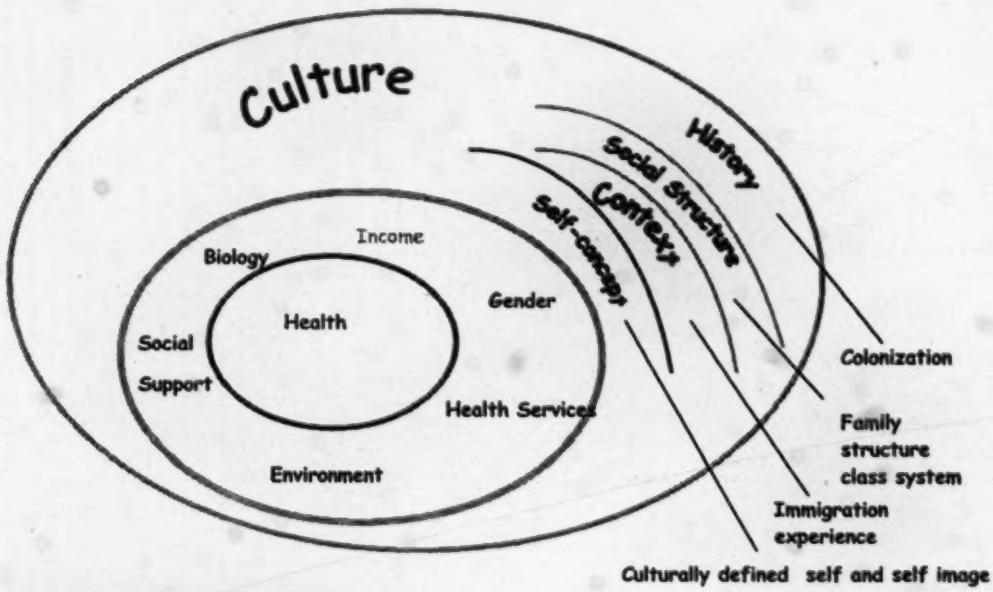
participants' commitment to direct the results of the study towards actions for change at the level of the multicultural health brokers, the MCHB Co-op and eventually the health system itself.

Cultural frame: a conceptual tool for understanding the individual health experience

The cultural frame articulates the human ecology framework and critical social science perspective in examining health issues and concerns at the level of individual experience. It was developed by Ellen Corin in 1995 and presented in this study as a conceptual tool to understand multicultural health brokering at the practice level – the arena where the multicultural health brokers work with individuals, families and community groups. The cultural frame is a useful tool for revealing multiple factors and contributing circumstances of the health issues of the individual or family. It is also a template for drawing a meaningful interpretation of the individual and family's health experience that incorporates operationalizing the determinants of health.

The cultural frame is grounded on the concept of culture as a tool that defines reality for its members and consists of a system of values, beliefs, norms and patterns of behaviour that have significance within the historical and social context of a group of people (Kagawa-Singer & Chung, 1994). Each culture defines health differently. While Western concepts of health may be explicit in their description of what it is, some cultures have no literal translation of the word "health" in their language. It is expressed in symbols and meanings, most often denoting the integration of mind, body and spirit. Kagawa-Singer and Chung (1994) added a cultural dimension to the concept of health when they defined health "as the ability to achieve one's life objectives within the beliefs and values of one's culture" (p.207). This definition underscores a subjective nature over biomedical measures of health and respects the individual experience of health within a cultural context (Corin, 1995). Corin (1995) referred to the cultural approach of the determinants of health, which requires a "thickening" of one's understanding of the health phenomena. Adopting a cultural perspective in health involves not only understanding the values, norms and beliefs of a specific group of people, but also to be able to view the experience of health and illness within a larger cultural frame as shown in Figure 1.

Figure 1 A Cultural Approach to the Determinants of Health



Adapted with permission from the author from: Corin, E.1995. The Cultural Frame: Context and Meaning in the Construction of Health. In Amick III et al. (Eds.) *Society and Health.* Oxford: Oxford University Press.

The Cultural Frame: context and meaning in the construction of health. This cultural frame is a conceptual band of layers of factors consisting of the historical experience, social structure and concepts of person and self – all important elements that interact to render meaning to a life event such as migration, illness or death. The historical experience refers to macro-social forces and conditions that shape the foundations of society and enable people to live through the world. This knowledge makes us conscious of the social origins of a disease, and how imbalances in power relations predispose health and illness. Colonization in the Americas stands as the most powerful example of historical and political oppression of Aboriginal peoples that had far-reaching and enduring

impacts on their health and quality of life. Many immigrants and refugees to Canada also come from homelands that were colonized or are presently in the midst of political turmoil and war. Social structures are the arrangement of statuses and roles that determine relationships within a cultural context and frame how people locate themselves in society (Corin, 1995). It is the arena where power roles are defined. For example, the secondary role of women relative to men still persists in many societies and accounts for an imbalance in the health status between men and women (ChapmanWalsh , Sorenson, & Leonard, 1995).

The concept of self is also defined differently in each culture. and consequently so is a positive self-image (Kagawa-Singer & Chung, 1994). For example, there is a wide difference between the self-concept of Westerners and Asians that could affect their interactions within a health care setting as well as in the workplace. Understanding mental health issues among ethnic minorities is often difficult for health providers who are not informed of some of the cultural nuances around mental health (Young et al., 1999; Kirkmayer et al., 1996).

Knowing all of the elements of a cultural frame and using this knowledge in defining health and its determinants sensitizes the analysis of personal and collective circumstances. This analysis weaves meaning into the experience of health and extends critical focus beyond the disease or illness. There are no single pathways to health or illness. All of the elements in the cultural frame interact with each other to form a consistent pattern that explains health. For example, studies of migration as a life event revealed varying degrees of meaning of culture and its impact on health. Migration to industrialized countries such as Canada may be less stressful for people who come from societies where material success is a dominant value but more stressful for people coming from societies which promote strong social bonds (Corin, 1995). The cultural approach to the determinants of health describes the health experience from the reality of the person, community and society. In this way, culture weaves a meaningful story of a life event and promotes an appreciation of, sensitivity for, and responsiveness to people's realities and experiences.

In summary, the cultural approach to health and its determinants espoused by Corin (1995) suggests a framework to identify the multiple layers of a health experience

called the cultural frame and offers plausible explanations that would give coherence and meaning to this experience at the level of the individual and his/her family, community and society. This framework helps to appreciate the holistic approach in the practices of the MCHB when they deal with the multiple issues surrounding the health issues of their clients.

V. A review of relevant literature

The purpose of a review of literature for this study is two-fold. The first is to establish the purpose, background and significance of the study. For this purpose I reviewed literature on cultural brokers and cultural brokering from anthropology as foundational concepts for the multicultural health brokering practice, including related studies on lay health workers. The second purpose is to use the literature as sources of data when developing the grounded theory of multicultural health brokering. In a grounded theory study, "everything is data" (Schreiber, 2000, p.14), including the literature. The review of literature is an ongoing process that that allows the grounded theorist to examine literature in relation to concepts emerging from the data (Chenitz & Swanson, 1986) and to contribute to the rigor of the findings (Schreiber, 2000). Although Glaser (1978) insisted that reading the literature beforehand might create preconceived concepts, there are methodological and pragmatic reasons for conducting a literature review (Chenitz & Swanson, 1986; Schreiber, 2000). Academic researchers are expected to possess some familiarity with the phenomenon being studied through the literature review; this would enable them to conduct the research with focus and direction (Chenitz & Swanson, 1986). Knowledge of the literature, in fact, promotes theoretical sensitivity when examining data and drawing concepts from the data (Schreiber, 2000).

Cultural brokering: addressing inequities in an imperfect world

Cultural brokering traces its origins to anthropology, where it was first introduced by Eric Wolfe in 1956 and Clifford Geertz in 1960 (Hopkins et al., 1977; Jezewski, 1990; Press, 1969). In Wolfe's and Geertz's studies in Mexico and Indonesia, they found certain individuals who "straddled between two sub-cultures and acted as

cultural translators and go-betweens" (Hopkins et al., 1977 , p.70). The "cultural broker", as they have named this person, is an "insider" (Geertz, 1960) and a member of the community (Press, 1969).

Margaret Connel Szasz (1994) made the first comprehensive and coherent documentation of cultural brokers based on studies of ethnohistorians. She narrated colourful, poignant and insightful stories of the people who were precursors of present-day cultural brokers. Szasz (1994) acknowledged the significant contributions of the cultural intermediaries between native and non-native peoples in shaping North American history when they "moved among the diverse peoples of the continent, breached language barriers, clarified diplomatic understandings, softened potential conflict, and awakened that commonality of spirit shared by the human race" (p.20). While cultural brokers were nurtured by personal circumstances and cultures, they emerged in response to historical conditions that oppressed indigenous peoples (Szasz, 1994).

The work of Robert Paine in the Canadian arctic in the late 1960s introduced another role of the "broker" as a person who "purveys values and deliberately processes information to make changes on emphasis or content (whether or not with the intent of mediation) " (Paine, 1971 , p.21). In Paine's experience, the brokers are not merely "go-between" messengers but agents of change. Richter (Szasz, 1994 , p.15) sees them "as participants in a world system approach serving as links between local political structures and regional international sources of power" (p.15) . This dimension introduces the brokers into a realm of power politics, creating alliances and engaging in diplomatic mediation between colonizers and native peoples.

The notion of cultural brokering in health also predates its modern practice, when spiritual intermediaries attempted to promote an understanding of western science and medicine with blended native healing (Szasz, 1994). The rapid post-war migration in the 1950s introduced cultural pluralism in the United States and Canada, which spurred interest in cultural intermediaries as both countries redefined themselves as multicultural societies. In 1971, Weidman (1982) formally introduced culture brokering in health in an ethnically diverse community in Miami for a community

mental health program. In this project, the cultural brokers were professional social scientists who acted as a bridge between the hospital and the community by training health professionals on the cultural factors influencing health and illness and teaching community members about the health care system (Weidman, 1982). It is interesting to note that the cultural brokers, while not necessarily indigenous to the ethnic communities, ushered in a catalytic role as they organized community groups towards social action goals to support mental health promotion such as food, security and housing. By the end of the 1980s, the term 'cultural brokers' gained wider acceptance in health and anthropology. In fact, a cultural broker role has been suggested as part of nursing care in multicultural settings (Jezewski, 1993).

Cultural brokerage and cultural brokering

Weidman (1982) first introduced the term "cultural brokerage" as an approach for health professionals to gain a better understanding of divergent health beliefs between the clinician and the patient. Cultural brokerage is an "intervention strategy of research, training and services that links persons of two or more co-equal socio-cultural systems through an individual, with the primary goal of making community service and programs more open and responsive to the needs of the community, and of improving the community's access to resources' (Tripp-Reimer & Brink, 1985, p. 128). If cultural brokerage is the approach or strategy, then the practice is "cultural brokering". Jezewski (1990) defines cultural brokering as the "act of bridging, linking, mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change" (Jezewski, 1990 , p.497). In the health arena, it involves "bridging gaps in cultural meanings or gaps in understanding between health professionals, the patient, his/her community and the broader social system" (Jezewski, 1990 , p.80; Jezewski, 1993). The following assumptions underlie the practice of cultural brokering (Weidman, 1982):

- There are cultures to be brokered and mediated. There is a distinctive <u>health culture</u> (emphasis mine) that includes "health values and beliefs and guides to health actions and relevant folk theories about promoting health, preventing and treating disease and illness" (p.130);

- There should be parity of cultures (emphasis mine) wherein two cultures, although not the same, are equal in value to the participants and thus build support and respect for the approach;

- There is a cultural broker (emphasis mine) who is willing to tread the "middle ground" and;

- The process of cultural brokering assumes "knowledge of the involved cultures and commitment to the synthesis of the various health traditions and various scientific disciplines" (p.130).

The cultural broker concept

Press (1969) defined the role of the cultural broker based on three concepts articulated in his early studies: ambiguity, innovation and the marginal person. Ambiguity is a concept wherein the broker acts in a "clear contextual capacity of the other culture achieving dual competence" (p.70). This ambiguous role allows the broker to accommodate a number of diverse perspectives that would open the door for negotiation. Innovation means that the broker in the process of bridging may circumvent traditional expectations and create new ways of doing things. This innovative role establishes the broker as a catalyst for change or change processes. Newcomb's (1956) concept of the marginal person is someone who is between two cultures and who operates at the borders of these two cultures to achieve a purpose (Press, 1969). As such, the broker's relationship with different groups may be fluid and involves constantly changing friendships and alliances depending on what outcomes are desired. The concepts of ambiguity, innovation and the marginal person shaped the cultural brokering practice of today. Within the health care setting, the cultural broker is seen as someone who navigates (most often in situations of tension and conflict) within two culture systems: one is the formal health system dominated by Western biomedical beliefs and traditions and the other is all non-Western cultures (Weidman, 1982). The notion of parity of cultures implies a symmetrical relationship between cultural brokers and health professionals, and also distinguishes a cultural brokers from an outreach worker. While typical outreach workers are agents of the dominant culture of which they are expected to promote, cultural brokers are purveyors of indigenous knowledge

and cultural traditions which may be different but equally important in addressing a health issue (Tripp-Reimer & Brink, 19.85).

It is also important to situate the cultural broker's role within a socio-political context, which has its origins in the colonial past of North America. We have seen that the cultural brokers from then were employed to confront the historical and social forces emergent at that time. Again, in contemporary society of diversity and inequality, similar political and social forces, though less turbulent, will motivate present-day cultural brokers to desire for social change. This means change that would free ethnic minority populations from marginalization and would bring them towards equality of access to resources and opportunities for health and well-being.

Eric Wolf (1956) appropriately articulated the importance of the role of cultural brokers in culturally complex societies:

> They stand guard over critical junctures or synapses or relationships which connected the local system to the larger whole. Their basic function is to relate community-oriented individuals who want to stabilize or improve their life chances, but who lack the economic security and political connections, with nation-oriented individuals who operate primarily in terms of complex cultural forms as national institutions, but whose success in these operations depends on the size and strength of their personal following. (p.1075-1076)

Recent research on cultural brokering

Two studies describe cultural brokering in a clinical setting. A study by Sharma (1988) examines difficulties experienced by nurses interacting with patients from diverse cultural backgrounds. Sharma (1988) recommended nurse-anthropologists who would broker information between the formal health care system and patients from culturally-diverse backgrounds to improve health outcomes. Jezewski (1989) conducted a study with migrant farm workers and constructed a grounded theory on cultural brokering in health in a migrant health clinic in New York. Her work was the first study to elaborate the cultural brokering process as experienced by nurses working with Hispanic migrants. Her model of cultural brokering described three stages – initiation, intervention and resolution (Jezewski, 1989, p.225). The processes involved in the stages are mediating, negotiating, sensitizing, innovation and advocating. It must be noted that in these studies the "cultural brokers" were nurses in the clinic, a departure from

the original concept of indigenous community members as brokers. Jezewski (1989) also observed in her research that non-professional health workers and interpreters have also functioned as brokers. Her research did not include them and suggested that further research is needed in this area to "broaden and densify the grounded theory of cultural brokering" (Jezewski, 1989 , p.225).

In Canada, literature on cultural brokering in health is sparse. A study on "Dragon Rise Team in Edmonton" documented the positive contributions of a group of Chinese nurses acting as cultural brokers who provided culturally sensitive health to Chinese and Vietnamese families (Morris et al., 1999). These "culture brokers" were nurses in a public health centre who were also indigenous to their own cultural communities. The Dragon Rise Team helped Chinese and Vietnamese families access culturally appropriate health care and achieved the health centre's objective of reaching populations who are at risk and isolated from the health care system (Morris et al., 1999).

The works of Geertz (1960), Paine (1971), Press (1969), Weidman (1982) and Szasz (1994) emphasize that cultural brokering emerged and thrived under conditions of marginality and domination. The role of cultural brokers flourished by bringing non-congruent aspects into a negotiated outcome beneficial to the individual or group who had been marginalized or disadvantaged. The literature reviewed in this section contributed to a greater understanding of the origins of cultural brokers and established the ideological and political nature of the cultural brokering process. The conceptual attributes of a cultural broker documented by Press (1969) proved useful in exploring the qualities of the MCHB participants in the research. Finally, Jezewski's (1989; 1990) works remain the most recent study into the conceptualization of cultural brokering in a health care setting. Her suggestions for further research on cultural brokering have also been taken up in this study. One is to explore the cultural brokering process outside of the clinical setting, and to include interventions other than those that facilitate medical treatment. The other is to capture the experience of non-health professionals who function as cultural brokers. The MCHBs are non-professional health workers indigenous to their culture, and their experience will broaden and enrich the existing cultural brokering theory that was developed mainly from the experiences of nurses who had acted as cultural brokers.

Lay health workers: harnessing community capacities for health

The significance of including literature on lay health workers in this research is the congruence of their roles to those of the multicultural health brokers. In most studies about lay health workers, there are two primary roles that have shown to be the most beneficial to the community and to the formal health system. The first one involves acting as "bridges", "cultural brokers", "connectors" and "liaisons" between the formal delivery system and the communities informal social support system (Corkery et al., 1997; Eng, Parker, & Harlan, 1997; Hill, Bone, & Butz, 1996; Love, Gardner, & Legion, 1997; Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). The second role revolves around providing three levels of support - emotional, informational and practical - to clients and their families (Addy, 1996; Corkery et al., 1997; Hill et al., 1996; Israel, Schulz, Parker, & Becker, 1998; Love et al., 1997; Schultz, Israel, Becker, & Hollis, 1997).

The idea of lay health workers originated from the concept of the "barefoot doctors" of the People's Republic of China in the 1950s in response to the scarcity of doctors and nurses. Barefoot doctors are "capable of responding to emergencies and of identifying and prescribing for common illness" and are practitioners of preventive medicine responsible for mobilizing people to take an active role in health care and sanitation (People's Republic of China., 1977 , p.1). These doctors are selected by their own community and trained in both Western and traditional Chinese medicine. This program has greatly influenced the development of village health worker programs in developing countries (World Health Organization., 1987). There are many fine examples of village health worker programs in Asia, Africa, and Central and South America that have successfully contributed to improving the health status of people and their communities (Donahue, 1986; Pagaduan & Ferrer, 1983; Ramontja, Wagstaff, & Khomo, 1998; Zakus, 1998). In developed countries, despite the availability of medical and health professionals, there is an emerging practice of using local residents or community members to provide the first line of response and on-going support when meeting the health needs of the community (Eng et al., 1997; Love et al., 1997; Roman, Lindsay, Moore, & Shoemaker, 1999; Sidebothanm, 1998). The reason for the emergence of community health workers, however, is not so much due to scarcity but for social and

practical exigencies. The idea of a trained community health worker was conceived to serve what health professionals have identified as "hard to reach" communities (Eng et al., 1997). These communities, whether geographic or cultural, find multiple barriers when obtaining health and related services, therefore placing them at a greater health risk than the general population. The community health worker as an intervention is guided by social support theories (Ell, 1996), the "helper therapy principle" (Roman et al., 1999) and resource development theories (Zakus, 1998). Community health workers, known by many names such as lay health advisors (LHA), health aides, community health representatives and "promontoras", are "indigenous to their community in which they work - ethnically, linguistically, socio-economically, experientially" (Love et al., 1997 , p.1). Most often selected by and from their communities, they have what Love (1997) call the "insider advantage". This "insider advantage" comes from their unique knowledge of the culture and strengths of their communities, which may be significant in reducing barriers to good health as well as facilitating positive health outcomes. The indigenous health workers are also geographically, culturally and socially accessible, especially for clients who require consistent or long-term care. The elements of trust and acceptability are essential to the effectiveness of community health workers, and these may be facilitated by the worker's inherent sensitivity to their community's culture (Addy, 1996; Baker et al., 1997; Eng et al., 1997).

The positive contributions of community health workers in various geographic and cultural communities are well-documented (Witmer et al., 1995). These contributions include increasing access to health care, improving quality of care, reducing the costs of care and most importantly, increasing social contributions to community growth and empowerment. These health workers have been and will continue to be valuable adjuncts to the formal health system and remain powerful advocates of community health issues and needs.

The literature on lay health workers guided this research towards a conceptualization of the MCHB role and also in comprehensively capturing their practice in meaningful and visible ways. The most important lessons from the lay health

workers' experience that informed the description of the multicultural health brokering practice were:

- Cultural authority and social responsibility for personal and community health can be shifted to the community from the health professional through the intervention of a CHW;

- Demonstration of a continuum of community-health institution partnerships within the context of the community's unique features; and

- Redefinition of the health professional-community health worker relationship to be less hierarchical and more collegial by acknowledging equal expertise in improving health service delivery.

Part Two
Methods

The construction of a grounded theory on multicultural health brokering was a collaborative process involving the research participants who are the multicultural health brokers, and the researcher. The collaborative process rests on the belief that the research participants are the primary actors in the research. The resulting grounded theory was the product of the multicultural health brokers' active engagement in generating the data and analyzing and finding meaning from the data through the process of theory building. I served as facilitator and resource person in the knowledge development process and in ensuring that the study demonstrated responsible and ethical research.

This chapter has three main sections: the first section introduces participatory action research as the study's philosophical and methodological orientation, the second section discusses grounded theory as a method of analysis for theory construction, and the third section demonstrates how these orientations were operationalized in the conduct of the research.

I. Participatory action research

Choosing a method is like choosing a language (Tseelon, 1991). The method of eliciting data represents a way of talking about reality and of constructing reality. Tseelon (1991) views methods as ideological because they are the codes through which facts are defined and acquire meaning. This study adopted participatory action research (PAR) as the philosophical orientation in organizing collective data gathering and analysis. The mandate and principles of the MCHB Co-op present a natural predisposition in the choice of the research approach for this study. This choice reflects the researcher as well as the MCHB Co-op members' desire for meaningful participation in mutual learning within the research process. A participatory action research (PAR) approach assures a comfortable "fit" with the MCHBs' personal and work orientation as well as maintaining the interest to pursue a critical stance in the conduct of the research.

Engaging multicultural health brokers in the research process comes from a strong sense of "protecting the community" from harmful outcomes of the research (Weijer, 1999), a key ethical principle in research. The values underlying PAR (Deshler & Ewert, 2000) that have helped shaped this research are:

- democratization of knowledge production and use
- ethical fairness in the benefits of the knowledge generation process
- an ecological stance towards nature and society
- appreciation of the capacity of humans to reflect, learn and change
- commitment to action and social change

These values have profound implications in defining the research question, identifying the participants in the research process, creating the processes and means to generate information for the production of meaningful and relevant knowledge, determining the direction of the benefits and outcomes of the research, and organizing the collective action and change resulting from participating in the research. PAR does not prescribe a set of methods to achieve the production of knowledge. Methods are determined by their appropriateness to the issues and the types of data that serve the learning and the research goals (Deshler & Ewert, 2000). Found (1997) strongly recommended dialogical and interactive methods whether it is within a one-on-one or group setting.

In participatory action research (PAR), the research participants are involved in developing the tools for generating data. Through community advisory committees, study circles, community research groups, etc., community members participate in developing interview questions (Bowes, 2000);(Israel et al., 1998; Idali Torres, 1998); (Cantrell & Walker, 1993; Henderson, 1995). (McWilliam, 1997; Plaut & Landis, 1992; Rains & Wiles, 1995)These are also training opportunities for research participants to learn about the research process and for research practitioners to share their knowledge. In this study, the participants themselves developed the set of questions for their own interviews.

For this research, the principle of mutual learning between researcher and research participants guided data collection and analysis. Smith (1997) asserts "people

are full subjects active in decision-making, inquiring, knowing, taking action and owning the knowledge, consequences and other outcomes of the research" (Smith, 1997, p.178). PAR is grounded on a fundamental belief in the richness of lay knowledge and that research should create the opportunities to articulate this knowledge, be affected by it and advance this knowledge to engender a collective will to act. Borrowing from Smith's PAR praxis cycle of "investigate-analyze-act", data collection and analysis will be an iterative process of education, awareness raising and action (Smith, 1997). This means that during the process of gathering data and analysis, some issues could emerge that would need immediate action even before the findings can be completely reported. For example, in this research there were some organizational issues that were identified during the interviews that could be addressed immediately. In order to ensure confidentiality and protect the identity of the participants, I posed questions to the Co-op members around a specific issue to allow open discussion by all members. For instance, several participants in the interview had indicated that the Co-op meetings needed to be improved. I administered a short questionnaire for the members about the need to reflect and assess the Co-op meetings. The survey showed great interest among the members in improving the effectiveness of the meetings. The members discussed the results of the survey and suggestions were generated and acted upon by the organization.

II. Grounded theory

Grounded theory guided the analysis of data to generate a substantive theory of multicultural health brokering practice. According to Creswell (1998), grounded theory belongs to one of the five traditions of qualitative research. The intent of grounded theory is the "discovery of theory from data systematically obtained from social research" (Glaser & Strauss, 1967 , p. 2). Grounded theory stresses that theory must come from data, as opposed to the *a priori* orientation to research of theory testing and verification (Wuest, 1995). Grounded theory is rooted in symbolic interactionism introduced by Mead in 1934 and elaborated by Blumer in 1935 (Chenitz & Swanson, 1986). "Symbolic interactionism focuses on the meaning of events to people and the

symbols they use to convey that meaning" (Baker, Wuest, & Stern, 1992). Chenitz and Swanson (1986) underscored several implications to research using the symbolic interactionism perspective. The first is that research examines human behaviours in interaction and all the factors and circumstances influencing the people's behaviours. The second implication is that the researcher assumes a dual role in the research – that of participant so he/she can enter the world of the participants and learn about their world and the "other" who can understand the world from the participants perspective (Chenitz & Swanson, 1986). The central research question in grounded theory is to answer "what is happening here?"

Glaser (1978) presents two models of theory development: the discovery model and the emergent fit model. The discovery model exhibits the true nature of grounded theory. The researcher does not have pre-conceived notions of the social phenomena being studied. Categories or concepts are discovered and analyzed throughout the research and form the basis for theory building (Glaser & Strauss, 1967). The emergent fit model recognizes that certain concepts already exist (pre-existant category). The task is to develop a "fit" between a pre-existant category and the data collected to arrive at a theory. This study falls into the emergent fit model of theory development.

Emergent fit model and sensitizing concepts

The emergent fit model recognizes that there are concepts found either in the literature or in people's experiential knowledge that have not been fully explored. These concepts could also describe a social phenomenon that people are concerned about and thus comes the need to investigate and find a theoretical formulation. Theory is not the monopoly of academic researchers. People in their everyday lives are guided by their own theories. The social world is filled with stereotypes, conventional wisdom and common sense; these are implicit theories familiar to people's everyday lives. There are also local theories unique to a particular setting and context that oftentimes influence and define people's thinking and actions. Whether these are implicit and local, these theories represent the way people understand reality and influence how they account and deal with environmental contingencies.

These pre-existing ideas or local theories are called "sensitizing concepts".

Sensitizing concepts originated from Blumer's critique of sociological theories that are removed from the empirical world (Van den Hoonard, 1997 citing Blumer, 1954 "What is Wrong with Social Theory?"). Blumer said that there are existing concepts that are meaningful to people, which researchers should explore so that they can be used to further explain people's experiences. Sensitizing concepts are "constructs derived from the research participant's perspective using their own language and expression and sensitizes the researcher to possible lines of inquiry" (Van den Hoonard, 1997, p.1). They also represent a higher level of abstraction from everyday theories because they are arranged to construct an analytical framework (Van den Hoonard, 1997). They become the foci of analysis and are treated as tentative concepts upon which a researcher undertakes the necessary work of data collection and analysis. In grounded theory, sensitizing concepts have a place in theory development if they will emerge from the data. Van den Hoonard (1997) cites Blumer's metaphor of sensitizing concepts as a "gateway" to the world of theory. As such, sensitizing concepts become "holding pens" for data conveniently grouped around an image that is usually created by the research participants (Van den Hoonard, 1997, p.29). It must be clarified that while a sensitizing concept can be used as a starting point for pursuing a grounded theory within the emergent fit model, it is allowed to develop along with the data rather than having preconceived ideas about it before collection.

In this study, the sensitizing concept is **multicultural health brokering** which is a term coined by a group of immigrant women known as multicultural health brokers to name their work in ethnic minority communities in Edmonton. Although there are associated concepts in the literature about their work, the women felt that these concepts could not thoroughly explain what they do.

Grounded theory offers a method by which the multicultural health brokers could fully explore and examine multicultural health brokering practices. Exploration and examination are central features of grounded theory. It offers a systematic process by which events, incidents or occurrences in our everyday reality are investigated for the purpose of arriving at an explanation of how they happened. Because it is most useful in studying areas about which little is known, grounded theory fits within the

multicultural health brokers' search for a coherent framework to explain their work. Alvesson and Skolberg (2000) classify grounded theory as one of the data-oriented reflexive methodologies. This is because grounded theory maintains its closeness to the empirical material ("everyday reality") as a basis for consequent induction until a theory emerges. This study is grounded on the experience of the research participants, the multicultural health brokers, who are the key contributors in generating a theoretical description of the multicultural health brokering practice.

Grounded theory is a method where data, which represents human behaviours in a social setting, is at the heart of theory development (Robrecht, 1995). It is the data that drives the analysis in the research and becomes the basis for developing concepts and their relationships to other concepts necessary to formulate a theory. An essential aspect of grounded theory is simultaneous data collection and analysis. This is done through the constant comparative method, where the first set of data e.g. first interview, is coded and analyzed and compared to the next set until a tentative conceptual framework can be derived (Glaser & Strauss, 1967).

Constant comparison method

Grounded theory applies the constant comparative method to analyze data by comparing it to emerging categories. Comparative analysis is an iterative process of assembling data into different categories until such time that the incoming information adds no new understanding to each of the categories. This is called saturation; the point when the researcher can no longer find any variations in the ongoing data collection and the same information is repeated with incoming data. Coding is the operational process for the constant comparison method. It is a process of examining the data i.e. interviews, field notes, focus group discussions etc., and formulating codes. Codes are preliminary concepts taken directly from the data. Coding has three levels that are sequentially structured to arrive at the highest level of abstraction, which is the theory. First-level coding involves the generation of open codes, which are the smallest conceptual unit in the study. This represents a single meaning derived out of phrases, sentences or paragraphs in the interview. Second-level coding is a process of

sorting the open codes and clustering them into what is called a category or the next level of concept. A category represents the synthesis of similar conceptual units. Third-level coding involves examining and inspecting for patterns and relationships among the categories to develop a unified and integrated concept, which is the emerging theory. The higher the coding level, the more distant the codes are from the empirical data, and the closer the data to conceptualization and theory construction (Glaser, 1978)

In past studies using grounded theory, academic researchers have dominated the analysis. This study undertook comparative analysis together with the MCHBs in focus group sessions. As Glaser and Strauss once said, "we contend also that it does not take a 'genius' to generate a useful grounded theory" (Glaser & Strauss, 1967 , p. 11). Grounded theory is a method that allows room for the analysis to be collaborative (Wuest, 1995). Focus groups, where emancipatory processes could be possible, are potential avenues to analyze varied "slices of data" (Glaser & Strauss, 1967) and to invite multiple perspectives in understanding a category (Wuest, 1995). Focus groups are strongly recommended by Blumer (1969) in the exploration of data; he calls them "discussion or resource groups" in the belief that

> discussing collectively their sphere of life as probing into it as they meet one another's disagreement [would] do more to lift the veils covering the sphere of life than any other device that I know of (Van den Hoonard, 1997 p. 6 citing Blumer, 1969, p.41).

Krueger's definition of a focus group is "a carefully planned discussion aimed at generating perceptions in an area of interest in a permissive, non-threatening environment " (Agar & MacDonald, 1995, p. 1). The use of the focus group method was aimed at two objectives: one is the collective generation and analysis of data and the other is developing the research participants' analytical skills in a group-learning atmosphere. The rationale behind the focus groups is to provide an opportunity where research participants can talk among each other about a topic of common interest and the focus of the research. Focus groups can be used for data collection and analysis because the information provided by each participant is processed and analyzed in the discussion (Asbury, 1995). Focus groups can be used in a variety of ways, such as "needs assessment, development or refinement of instruments and exploration of the

interpretation of data" (Carey, 1994, p.24). Focus groups have also been found to be appropriate for culturally diverse groups because the non-threatening group process allows the expression of differing ideas (Hughes & DuMont, 1993). A focus group can be used solely as a method for generating data or in conjunction with other method such as one-on-one interviews or quantitative methods (Asbury, 1995). Van den Hoonard (1997) also suggests focus groups as a powerful tool for exploration of data where the participants are intimately involved in the phenomenon being studied. Focus groups not only keep the researcher's perceptions grounded on the empirical data, but also demonstrates a respect for the dignity and opinions of the research participants (van den Hoonard, 1997). This view is congruent with the ethical principle of participatory action research: respecting people and communities. In this study, a focus group method was used for collective data collection and analysis. The study adhered to the norms of conducting focus groups as elaborated by Agar and MacDonald (1995), Asbury (1995), Carey (1994), and Hughes and Dumont (1993). These norms included selection of study participants who have a common experience (Agar & MacDonald, 1995; Asbury, 1995), size of the group not to exceed beyond twelve participants (Carey, 1994), use of guide questions and exercises to aid discussions and group work (Asbury, 1995; Carey, 1994; Hughes & DuMont, 1993) and analysis of the focus group data for theory construction using focus group documentation in flip charts (Carey. M.A., 1995; Glaser, 1992). This collaborative analysis and theorizing opens up the sharing of power between academic researchers and research participants.

Grounded theory stands as the method most congruent to the diversity of the MCHBs. By nature, grounded theory seeks multiple perspectives to illuminate and enrich the theoretical properties of emerging concepts (Glaser, 1978). In this study, multicultural health brokering is experienced by a group of women from different cultural backgrounds and life contexts. All of them had the opportunity not only to generate data but also to conceptualize their individual experiences into a theoretical formulation that will have shared meanings for all of them.

Finally, a grounded theory is meant to be a set of integrated hypotheses waiting to be proven at a later time (Glaser, 1978). The test of grounded theory is not about

proof within the context of testing and verification, but whether the theory is credible enough to be recognizable to people who know best about the area of study. A good grounded theory according to Glaser and Strauss (1967) must have "fit", "grab" and must "work". Fit means the data can generate categories that can be applied to other data (Chenitz & Swanson, 1986). To have a grab means that the theory is easily recognizable to the research participants (Rita Schreiber, 2000). To work means that the theory should be able to explain what happened, predict what will happen and interpret what is happening (Glaser, 1978).

A critical social science perspective to grounded theory

The evolution of the practice of grounded theory as well as the emergence of newer paradigms has stirred grounded theorists into re-looking at the philosophical roots of grounded theory. The original grounded theory owes its roots to classic Blumerian symbolic interactionism; a microsociological theory that does not deal with larger societal questions, which influence the social action of individuals. Glaser (1967) believed that variables such as race, class or gender should earn their way into the theory. When Strauss and Corbin in 1994 introduced the *conditional matrix* to increase the theoretical sensitivity of grounded theory to issues of class, gender, race and power, it had begun its journey towards critical theory (Annells, 1996). Barnes (1996) agrees with this direction, as she argues for culture to be integrated into grounded theory's analysis. Wuest (1995), from a feminist theory perspective, saw potentials for grounded theory to be productive in uncovering macro-social issues that influence the interactional process. The critical social science perspective renders assumptions of race, class or gender explicit so that they can contested or affirmed in the research process (Eakin et al., 1996).

On epistemological issues, there is a growing congruence between CSSP and grounded theory. Classic grounded theory explicitly leads the researcher to "come closer to objectivity" (Glaser, 1978, p.8). Yet, in his latest book, even as Glaser (1992) urged practitioners not to force data into their perspective, he conceded that "once the general concern emerges, it is almost sure that the [researcher's view] has varying property of it [data]" (p.23). Annells (1996) traced the development of Straus and

Corbin's epistemological perspective: from the researcher being actively involved with the method (1987) to researchers drawing on their experiential knowledge, including ideological orientation into the research process (1989). Baker et al (1992) concurred with Straus and Corbin that the researcher is a social being who also creates and recreates the social process, and the critical social science perspective fully supports this view because research " is not a neutral procedure for discovering an 'objective" external reality that exists independent of human perception and interpretation" (Eakin et al., 1996, p.158). In grounded theory, previous experience is data that includes the researcher's personal and professional experience, from which insights, hunches and generative questions for data analysis may all come (Barnes, 1996).

In the critical social science perspective, the differential distribution of power is central to the construction of reality (Bubolz, 1995; Eakin et al., 1996). The power distribution extends to the research process itself and demands that the researcher be critical of his/her own power and to initiate the act of power sharing with research participants during the important aspects of the research. This may include defining the research question, participation in collection and analysis of data, and ownership of knowledge produced in the research. In this study, the critical social science perspective is reflected in two substantive areas of the research. The first is the choice of participatory action research as a philosophical orientation in the conduct of the research. Using PAR commits the researcher to sharing power and control of the research with the research participants, adhering to democratic ideals of decision-making and exercising ethical conduct with regards to knowledge generation and development. The second area is in the analysis of the data in content and process. In the study, the questions were structured to reveal issues of marginalization as experienced by the multicultural health brokers as a worker interacting with the health system and with the individuals, families and communities they serve. The resulting theory that will be presented later in this study accounts for processes in the multicultural health brokering practice that seek to explore and address issues of inequities at the level of individual and the family within the broader context of community and society.

III. Collaborative research and theory building: A participatory journey with the multicultural health brokers

This section will describe how participatory action research orientation and grounded theory were used to create and put into practice a collaborative process of data generation and theory development. The journey begins with planning the research with the multicultural health brokers, framing the research question and developing the interview questions for data collection, analysis and theory building.

Planning the research with the MCHBs: nurturing a culture of learning

The core of authentic participatory action research lies in negotiating a shared set of values and norms that will guide the research process (Israel et al., 1998). PAR espouses a code of ethics or ethical principles that reflect the values and beliefs of the research participants, and also resonates with the fundamental principles of justice, democracy and mutual respect. There is a growing body of literature both in theory and practice that supports the notion of collaborative formulation of ethical principles as a starting point for any participatory and community-based research (Israel et al., 1998; Macaulay et al., 1999; Weijer, 1999). The idea of protecting communities from research was a consequence of negative impacts and was most often due to the harmful outcomes of past research in communities (Weijer, Goldsand, & Emanuel, 1999). Protecting communities from harm propelled efforts at developing ethical principles with community members. Communities, in this sense, refer not only to geographic communities but "of a group of people sharing a common interest - cultural, social, political, health and economic" (Macaulay et al., 1999 , p.775). The importance of engaging the community early in the research lays the groundwork for a partnership between the community and researchers (Weijer, 1999). This preparatory work not only establishes the democratic legitimacy of the research process, but also ensures that the ethical ground rules are comprehensive and address the "concerns that arise from the traditions and values unique to and constitutive of the community" (Weijer, 1999). Weijer, Goldsand & Emanuel (1999) refer to "respect for communities" previously termed by Levine as "respect for culture" as the fourth ethical principle in addition to

respect for persons, beneficence and justice. Respect for communities acknowledges the inseparable nature of individuals and their communities as well as its moral status as a collective participant in the research (Weijer, 1999). Finally, it confers upon the researcher an obligation to respect the values of the community and, wherever possible, to protect the community from harm.

On February 7, 2000 the MCHBs met to discuss and develop a set of ethical principles for the research. Although there were some cultures that did not have the word *ethics* in their language, the MCHBs agreed on fundamental ethical questions that became the basis for developing the research ethics and principles. These questions centred on who determines the purpose and objectives of the research, who participates in the accomplishing the objectives, who uses the benefits and outcomes of the research and who evaluates the results and outcomes of the research. While these questions came from the MCHBs' experiential knowledge and sensitivity, they also reflect emerging elements of authentic participatory action research. Concepts such as ownership and control of the research process (Cancian, 1993; Deshler & Ewert, 2000; O'Neil, , Kaufert, & Koolage, 1993; Guerrero, 2000; Hall, 1992; Macaulay et al., 1999; McNicoll, 1999; Sohng, 1995), rights to benefits of research (Kothari & Fundacion Sabiduria Indigena (FSI)., 1997) and ethical relativism (Scupin, 1998) are well documented in the literature.

The MCHB research ethics and principles primarily define the boundaries of power within the research relationship that, in the participatory action research context, resides in those who are participants in the research process. In a collaborative setting, it is essentially an articulation of the shared philosophy and values of the research practice that will ultimately build trust and commitment in the research relationship. The MCHB Research Ethical Principles (Figure 2) guided the conduct of this research and have been helpful in preventing conflict and tension between the researcher and the research participants. According to the participants, the research process in this study was attentive and respectful of each individual's decision to participate or not to participate. Each member of the MCHB Co-op had the opportunity to be engaged in various stages of the theory's construction.

Figure 2 MCHB Research Ethical Principles

Our Research Ethics

Developed by the MCHBs on March 27, 2000

Our Values and Principles

1. Respect for people's rights
   - right to consent or dissent
   - right to privacy and confidentiality
   - right to benefit of the research
   - right to participate in all aspects of the research

   The research will ensure that these rights determine the research process.
2. Valuing people's knowledge, experience and capacities in influencing the research process.

   The research will engage the participants in the design, conduct and dissemination of the research.
3. Sensitivity to people's life circumstances and experiences.

   The research will be attentive to issues, needs and concerns of research participants and will seek ways to address those needs and issues.

Principles of our Research Practice

1. Clarity of purpose of the research

   The objectives of the research should be clear and collectively determined by all those involved.
2. Full participation of research participants in all aspects of the research
   - *Defining the research questions to make the research relevant and meaningful to the needs and interests of the participants.*
   - *Planning the research to ensure that people's experience and knowledge can direct the course of the research.*
   - *Collecting and generating data is a deliberate effort to achieve mutual learning.*
   - *Analyzing data seeks to integrate perspectives of the research participants to increase understanding of the issues being studied.*
3. Full access to results of the research

   All efforts at removing barriers to greater understanding of research results will be made.
4. Rights to benefits of the research.

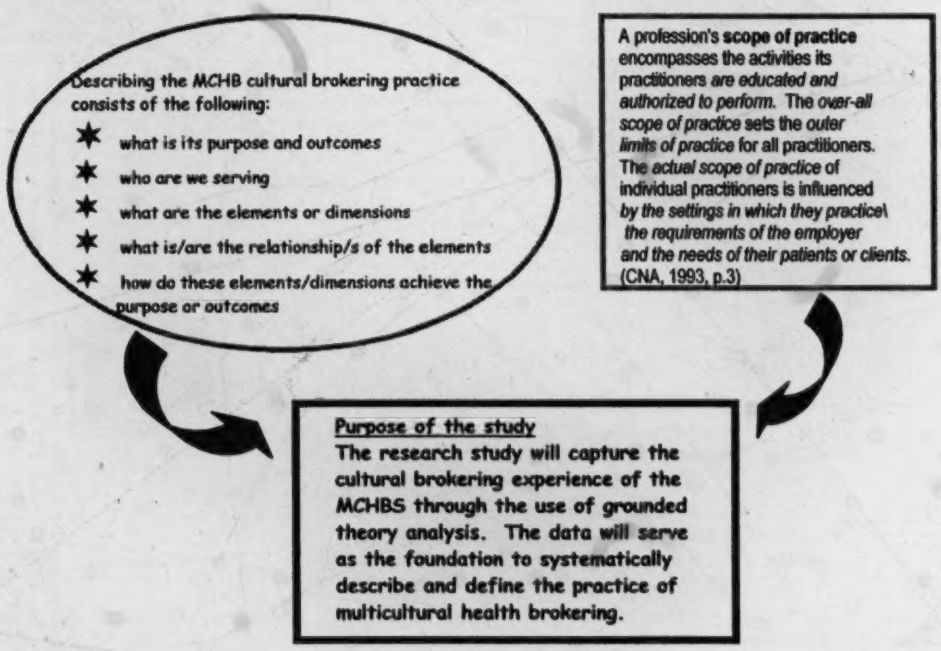
   There will be full acknowledgement of the research participants to the benefits of the research in the dissemination of results, which could be in the form of authorship, funding opportunities and publication.

Framing the research question

The next step after developing the ethical principles for the study was defining the research question. "What questions do we ask ourselves so that we are able to describe what we do not only to ourselves but to others?" This was the MCHBs' starting point for framing the research question. The MCHBs chose their experience as an originating framework for their research questions. I referred to the Canadian Nursing Association's (CNA) definition of the scope practice (see Figure 3 for definition) in understanding the nature and elements of describing a practice. Figure 3 shows the key areas of investigation and the research purpose.

Figure 3 The Research Question and Purpose of the Study

Our research question: What is cultural brokering as practiced by the multicultural health brokers?


Describing the MCHB cultural brokering practice consists of the following:
what is its purpose and outcomes
who are we serving
what are the elements or dimensions
what is/are the relationship/s of the elements
how do these elements/dimensions achieve the purpose or outcomes
A profession's scope of practice encompasses the activities its practitioners are educated and authorized to perform. The over-all scope of practice sets the outer limits of practice for all practitioners. The actual scope of practice of individual practitioners is influenced by the settings in which they practice\ the requirements of the employer and the needs of their patients or clients. (CNA, 1993, p.3)
Purpose of the study
The research study will capture the cultural brokering experience of the MCHBS through the use of grounded theory analysis. The data will serve as the foundation to systematically describe and define the practice of multicultural health brokering.

VI. Data collection and analysis using participatory action research and grounded theory

This section will describe the construction of the theory on multicultural health brokering focusing on the "technical aspects" of the grounded theory and the co-operative process of analysis and conceptualization. The subsequent sections highlight the phases of theory construction in chronological sequence. Some examples were provided to show how raw data from the interviews was organized and analyzed to become the building blocks of theory.

Developing the interview guide

The primary data collection tool was an interview guide designed to lead the

face-to-face interviews with the multicultural health brokers (MCHBs). The research participants (MCHBS) themselves developed this guide, which was used by the researcher. On February 21, 2001 the MCHBs held a workshop to design an interview guide for the research. They answered the question, "If you were to ask your colleague about her experience as an MCHB, what kind of questions would you ask?" Small groups were organized to work on questions relating to the actual description of the practice: the qualities of a multicultural health broker and their thoughts about the MCHB Co-op. A total of 64 questions were formulated in the workshop. I collapsed some of the questions and came up with a final list of 26 open-ended questions that were presented to the MCHBs for their approval. The interview guide also contained introductory questions which included the participant's immigration history to Canada (country of origin, date of arrival, length of stay, languages spoken, newcomer experience and occupational history) as well as their recollection of how they became a multicultural health broker. The list of questions in the interview guide was designed as a reminder to the interviewer (the researcher herself) that these are specific areas the multicultural health brokers wanted covered. In many instances, the participants had answered most of the questions without being asked by the interviewer. (Please see Appendix C for the interview guide questions.)

There are no hard and fast rules for developing a theory using the grounded theory method. Glaser and Strauss (1967) and Glaser (1978) provided a comprehensive guide to grounded theory development but did not prescribe a step-by-step process on how one should proceed from the analysis to the final theory construction. Every grounded theory researcher formulates his/her own style or methods of work guided by the work of Glaser and Strauss and researchers who had experienced using the method in their studies. In this study, I extensively referenced Glaser (1978), Schreiber (2001, Van den Hoonard (1997) and Jezewski (1989) in designing a collaborative and participatory process to develop a grounded theory on multicultural health brokering.

In brief, the steps below were created specifically for this study to operationalize a collaborative process using grounded theory.

1. Phase I interviews involved individual interviews with seven multicultural health brokers as the pilot interviews to generate data to initiate the coding process.

2. First-level coding involved generating open codes from the interview transcripts in a focus group. The participants examined their own transcripts and identified codes using their own words.

3. Phase II interviews involved interviewing eight multicultural health brokers, comparing their interviews using the first level open codes and generating additional codes.

4. Second-level coding involved sorting the open codes and clustering them into similar and/or related ideas in a second focus group session. The cluster of open codes produced categories and their properties. Second level coding is an iterative process comparing open codes with one another and shifting them from one cluster to another until all possible conceptual ideas are exhausted.

5. Third-level coding involved examining and inspecting the categories seeking patterns and relationships. The multicultural health brokers were actively engaged in this process using their experience as a reference to find meaning among the categories. Once the research participants defined the patterns and relationships, Glaser's (1997) 16 Coding Families or theoretical typologies were used as a guide to formulate the emerging theory.

6. The validation workshop was an opportunity to discuss the emerging theory on multicultural health brokering with all members of the MCHB, including those who were unable to participate in the research. The purpose of this workshop was to ensure that the theory reflected their experience, provided clarity of their work and gathered additional perspectives to further enrich and strengthen the theory.

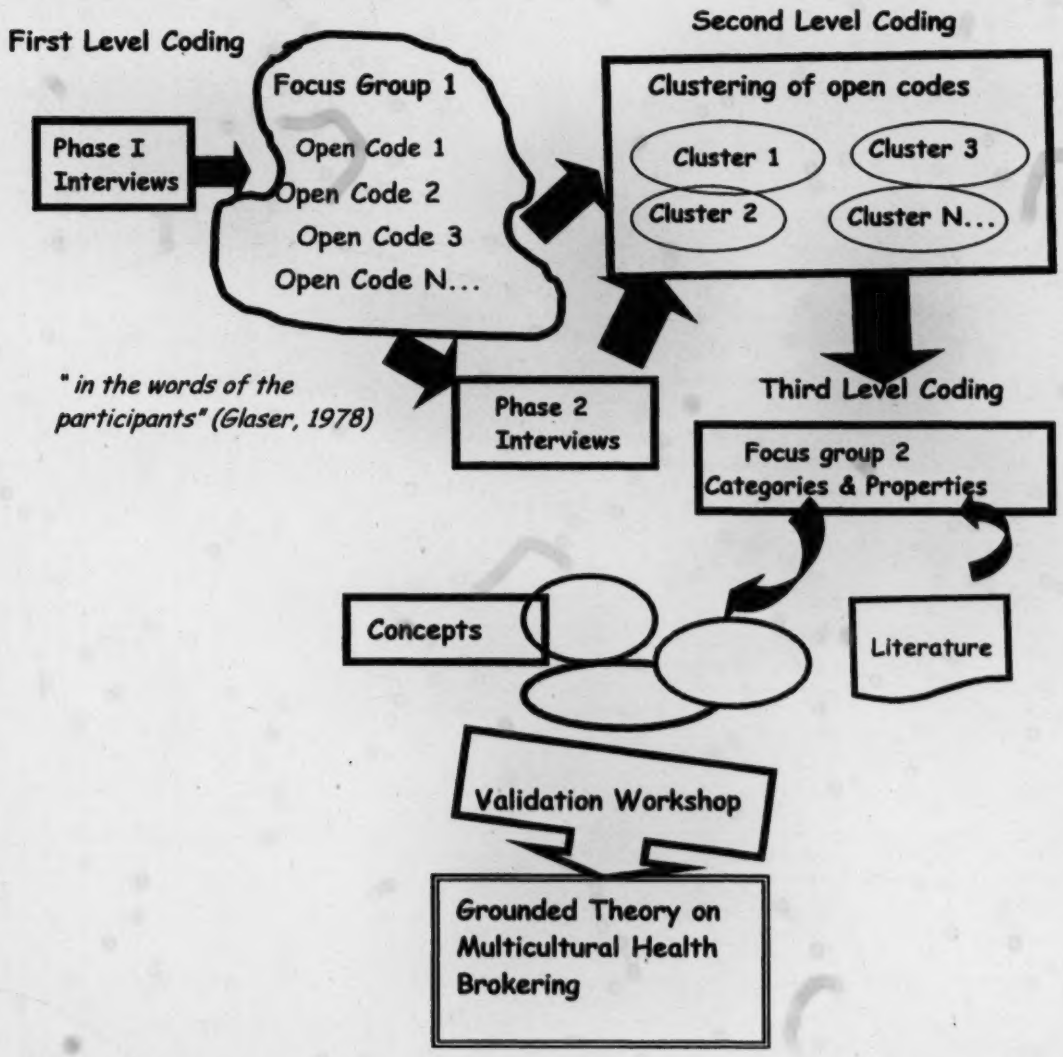
Figure 4 shows the collaborative theory building process. The subsequent section will describe in greater detail the collaborative process of theory construction used in the study.

Phase 1 Interviews

The purpose of the Phase I interview was to generate information about the work and experience of the multicultural health brokers and how they perceived the multicultural health brokering process. The first set of interviews was conducted from March to April 2001, with seven MCHB Co-op members from each of the cultural groups represented in the Co-op (Chinese, Vietnamese, Spanish-speaking, Arabic speaking and South Asian). Most interviews were held in offices, some in community

centres and others were in the homes of the participants. The length of the interviews ranged from one and a half hours to two hours. All of the interviews were conducted in English.

Figure 4 Collaborative Theory Building



The taped interviews were transcribed verbatim. Each participant received a copy of their own interview transcripts to allow them to check the accuracy of the transcription. The participants had mixed reactions to their own transcripts: some were

surprised at how much data their interviews contained. Others were self-conscious of the way they expressed themselves. On the whole, the participants appreciated the opportunity to check back on their interviews. This gave them a chance to decide whether they would still like to participate in the study, as guaranteed in the ethical principles. All of them decided to continue their involvement in the research.

The interview transcripts were stored in a NUDist software program at the University of Alberta. This computer software is highly versatile in organizing open-ended data, makes the coding of large qualitative data easier and efficient and is compatible with word processing programs.

In grounded theory, coding begins after the first interview. The resulting codes are used to compare the previous interviews with the next interview as well as to further explore new codes in succeeding interviews. The codes were the exact words spoken by the participants during the interviews. However, for Phase I data gathering, the seven interviews were treated as first interviews to find out if cultural variations would surface in the individual experience of multicultural health brokering, noting that the participants come from diverse cultural backgrounds. As the interviews progressed, a preliminary set of codes was drawn from each completed interview and compared with the next interview. The codes also helped probe the responses in the next set of interviews.

Focus Group 1 – First-level coding

First-level coding is the first step in the analytical process of grounded theory. This phase involved identifying key themes from the pilot interviews, which will be the basis for developing the first level of codes. First-level codes are small portions of data that can be conceptualized. The research participants examined the data from their own interviews and generated key themes using the reading guide method (Kelly & Van Vlaenderen, 1996; Henderson, 1995). This method involves providing a set of guide questions to help the reader identify common themes. At this level of coding, codes were generated using the words of the participants as the labelling unit.

The first focus group was held on November 21, 2001, and was attended by six out of seven participants. The purpose of this session was to generate and explore the

first-level codes or open codes from the actual interviews. The transcripts of their interviews were given to the participants a week before the session. The transcripts contained bracketed sections to identify the relevant parts for the focus group based on specific questions in the interview guide. The bracketed sections included the parts where they described how the participants had responded to the issues presented by their clients, the interventions or strategies they had adopted and their role as multicultural health brokers. (Please see Appendix D for Focus Group Invitation.) The participants were instructed to give particular emphasis to these sections since they would be generating codes from these sections. I coded the seventh interview of the MCHB who was unable to attend the focus group.

Glaser (1978) recommended that the initial coding should come from "the participants' own words". The use of participants' own words at this level of coding has anthropological roots. It is called the "emic" approach where the concepts that will be derived out of the research process are grounded in the participants' worldview and how they understand their experience (van den Hoonard, 1997). As a novice researcher in grounded theory, the use of a participant's own words eases the anxiety of having to find words to describe the participant's experience when his or her natural language can fulfill the purpose. In the focus group session, the participants were asked this question: "What happens in the multicultural health brokering process?" They were to draw "key words" from the bracketed sections in their own interviews. The "key words" would be actual words they had said in the interviews. The "key words" would become the first-level codes, also known as open codes, *in situ or in vivo* codes where aspects of data are conceptualized using the participants' own words (Schreiber, 2001).

The participants generated 44 open codes from their interviews. Because of time constraints, the participants randomly selected 23 open codes and further described each code based on insights from their work. These descriptors proved helpful in the succeeding coding process and later in identifying some of the categories. The participants produced an average of six descriptors for each open code. (Please see Appendix E for complete list of open codes.) The statement below is an excerpt from an interview where several open codes (underlined words) were obtained:

> To help them listen to their problems and clarify their problems and look at their problem at their way, so they can talk to me about their problem and also interest them and help them to analyze their problem, and they can solve it on their own.

The other 19 codes were clustered with the 23 codes that had similar meanings. For example, the open code that was not discussed in the focus group, "helping to access" was clustered together with "connecting". The open codes developed by the participants were used to re-code the pilot interviews and stored in the NUDist program. I discovered that there minor differences in my initial codes compared to those of the participants. These differences were attributed to the selection of the words or labels to appropriately describe a specific incident, process or event. For example, participants named a paragraph in their interviews ("working together") as a code. I had coded the same paragraph as "collaborating".

Phase 2 Interviews

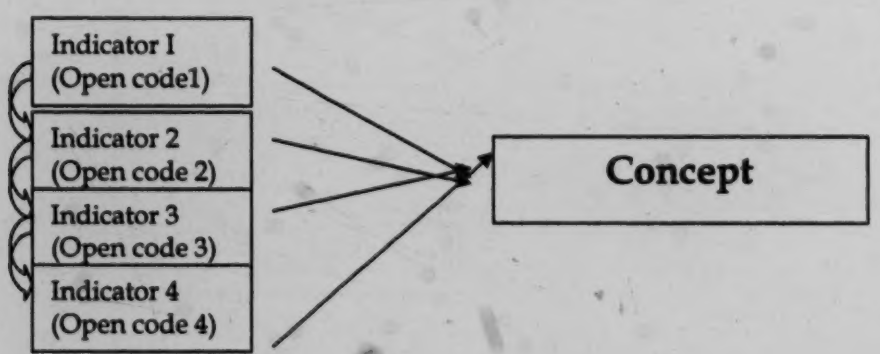
The second-phase interviews were conducted from November 2001 to January 2002; and involved eight participants from five cultural communities (Chinese, Spanish-speaking, South Asian, Somali and East European). Out of the eight, two were not members of the MCHB Co-op but were providing multicultural health brokering services in one of the Co-op's projects. The interviews in this phase incorporated additional probing questions to further deepen and saturate the first-level codes from the Phase I interviews. New open codes also emerged from the Phase 2 interviews, and were added to the original list. The Phase 2 interviews resulted in a total of 56 open codes. These open codes will be analyzed in the next level of coding.

Focus Group 2 - Second-level coding and categorization

Second-level coding raises the open codes to the next level of abstraction – from the participants' direct experience as expressed in the open codes to ideas and themes. This process involves examining for similarities and differences in ideas and meanings among the open codes (Schreiber, 2001). Open codes that appeared to be similar in content and meaning were clustered together. A unified meaning or concept would

then be conceived for each cluster of open codes. This is similar to the process of "theming", where several ideas that convey a similar meaning are grouped together into one single broader concept. The idea of theming is an application of Glaser's (1978) "concept and indicators" model. This model as used in the study provided the essential link between data and concepts that will create a theory from the data. It involves identifying a set of empirical indicators, also known as open codes, and comparing one indicator to another. From the comparison, the analyst searches for differences and consistency of meaning among indicators. The outcome of such a process is a sense of uniformity or consistency of meaning between indicators from which a category or conceptual code can be defined. The diagram below shows Glaser's concept and indicators model. An example of how this process was used in the research will be provided later in this section.

Figure 5 Concept and Indicators Model (Glaser, 1978)



Prior to the second focus group, all 56 open codes were tentatively clustered based on my own understanding of which open codes seemed to cluster together. This understanding was shaped by emerging coding patterns in the data, my current knowledge of the work of the MCHBs, literature on cultural brokering and more recently my own experience of responding to a referral from a public health nurse (a specific section was presented earlier in the study, please see Part One).

The second focus group was held on February 8, 2002 and was attended by nine participants out of a total of fifteen. This included those who had participated in the

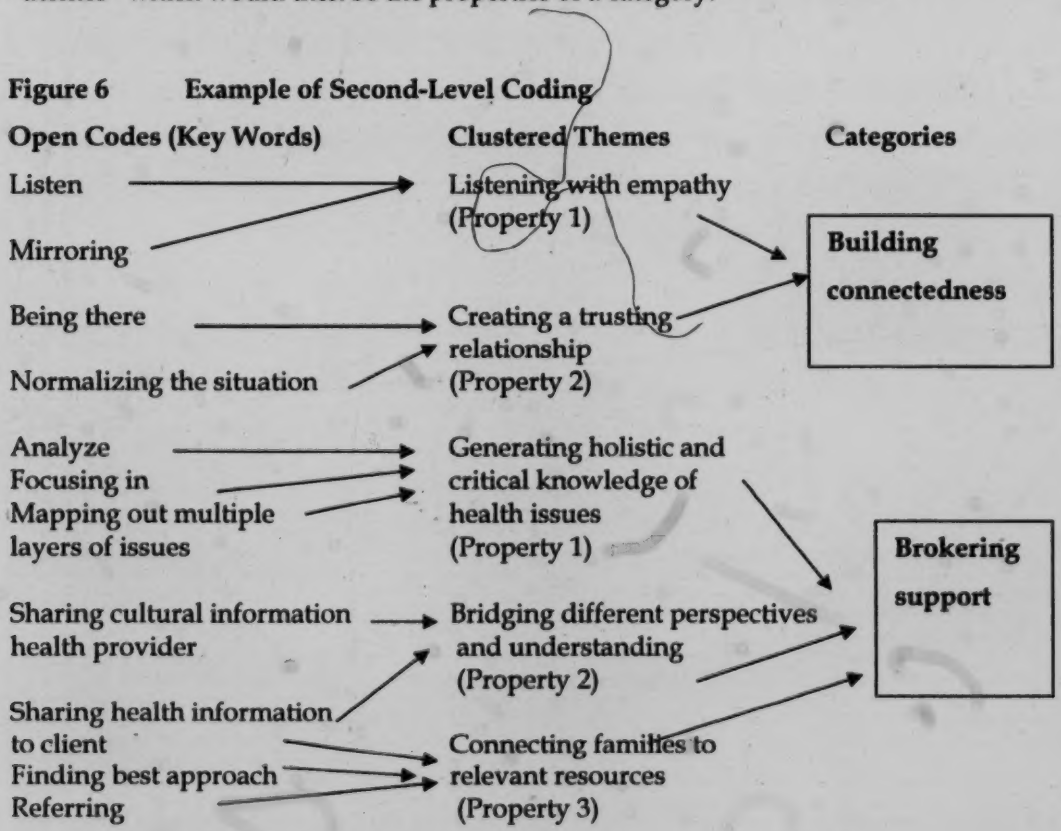
Phase 1 and 2 interviews, and the first focus group. (Please see Appendix F for Second Focus Group Invitation.) I invited a nurse who worked closely with the MCHBs in the last eight years. She has consistently provided technical health content to the work of the MCHBs and has mentored them in working effectively with mainstream health service providers. Her knowledge of the MCHB work is deep, and nurtured from the time she had mentored them as perinatal health educators in 1992. She brings to the analysis a fresh perspective as an outsider, yet is still someone profoundly familiar with the work. Mays and Pope (2000) recommended that an outsider, someone who is not involved in the research but who is knowledgeable in the area of the research, review the findings and the research process to increase the internal consistency and reliability of the analysis.

The open codes generated from the first focus group and the Phase 2 interviews were grouped together into eight clusters describing common themes or content. In this focus group session, the participants were asked to examine the open codes from each cluster in terms of how they were similar or different as well as how they reflected the things they do as multicultural health brokers. During this examination some open codes were taken out from their original cluster and placed in another cluster, and new clusters were created that did not belong in the original cluster. (Please see Appendix G for list of clustered open codes.) In clustering the open codes, the discussions of the participants were written in flip charts and served as data in generating more codes.

The next step in the analytical process was to examine each cluster to derive concepts out of these groups of open codes. Since the participants were familiar with "theming", they were asked to look for "themes" that would describe or represent each cluster. These "themes" may lead to concepts and categories. In the actual process, the open codes (indicators) were compared with each other, how they fitted with the experience of the MCHBs, and then were used to create a conceptual code or codes to form different clusters of open codes. While examining the clusters, it was difficult at the beginning for the participants to find one theme for each cluster that would capture the substance of the group of open codes. We decided to keep two or more conceptual codes for some clusters and went back to them for another iteration. The next iteration of conceptual coding reduced the conceptual codes to one for each cluster. The selection

of the second-level codes, which are now labelled as categories, was based on the participants' consensus that the "words or phrases" captured the essence of what was going on in that particular cluster. The clustered codes also gave leads in terms of potential properties or attributes of a category. A grounded theory is made up of what Glaser (1978) calls conceptual categories and conceptual properties derived from the constant comparison method. A category is a "conceptual element of the theory while a property is a conceptual aspect of a category "(Glaser, 1967 p.36). A category is a synthesis of related ideas similar to a family of terms. A property is a specific attribute that delineates a category. Properties define or describe a category. Each category has a property or properties drawn from the data that makes it distinct or unique from other categories. Figure 6 shows the progression of two groups of open codes into clustered "themes" which would then be the properties of a category.

Figure 6 Example of Second-Level Coding



Glaser (1978) reminded analysts that categories and properties are concepts and abstractions from the data and not the data itself. The concepts must not be confused

with using a term from the data (such as interview transcript) to name or label a category. The category as a conceptual element must earn its way in the analysis. The ordering of concepts in a grounded theory analysis would be open codes, properties and category. Each step possesses higher levels of conceptualization.

Third-level coding or conceptualization

The purpose of third-level coding is to search for patterns and relationships among the different categories (Schreiber, 2001). While the first- and second-level coding remained grounded in the empirical data, third-level coding is what Van den Hoonard (1997) calls "taking distance from the data" (p.22). This process begins the path to theoretical abstraction, where patterns and relationships are culled from the categories.

In the second focus group session, we attempted to look for patterns among the eight categories we had generated. The group reached a consensus about two types of patterns emerging from the categories. The first is a temporal pattern where the different categories can be laid out as a series of processes occurring in time. The categories are related to each other in a logical as well as a chronological sequence. The second pattern involved a set of dimensions defining the scope of the multicultural health brokering practice. These temporal patterns and dimensions were again validated with data from the interviews. For the conceptualization process, the focus group participants used Glaser's Coding Families to assess the theoretical feasibility of the patterns and relationships occurring in the data. Coding families are typologies of concepts that Glaser (1978) organized to aid theorists who are looking for patterns in their coding.

Two coding families were identified: the process and dimension families (Glaser, 1978). The process family involves stages over time. It has a beginning and an end. It must have at least two stages. The multicultural health brokering practice has four stages occurring over time and follows a logical sequencing of stages. The dimension family involves pieces or parts of a whole. A grounded theory of dimensions will reveal what constitutes the theory. The dimensions family specifies what makes up the practice of multicultural health brokering. The data revealed that multicultural

health brokering is a multi-dimensional concept that captures multiple focal areas of work. The resulting grounded theory of the multicultural health brokering practice is a synthesis of the process and dimensions family.

Final validation of the grounded theory

A workshop was conducted on March 4, 2002 to present and discuss with the MCHBs the theory generated from the analysis (Please see Appendix H for workshop agenda.) The purpose of the validation workshop was to ask the participants whether the emerging theory of multicultural health brokering explained their experience and practice. In addition, the workshop also sought to gather more insight about the emerging theory. Sixteen (16) out of 18 members of the MCHB Co-op including those who did not participate in the interviews, attended the workshop. The process used for validation involved an aided theory building exercise using results from the second focus group session. This is meant to allow the participants to experience theory construction. The participants were asked to construct a theory out of the identified categories in the focus group session. In this process, the true analysts are the multicultural health brokers, since they themselves know the most about their work. They would have the sensitivity to determine the explanatory power of the emerging theory. Their experience (empirical data) grounds the theory and establishes its relevance and fit to their reality. At this point, the researcher stepped back from the process and allowed the participants to determine for themselves whether the results of the study had adequately articulated their experience. The MCHBs were asked whether the emerging theory captured their experience and whether it will be useful in defining their practice. There was a consensus among the participants that the grounded theory on multicultural health brokering articulated their practice. The process of arriving at a consensus involved asking each of the participants whether the emerging theory spoke about their work. Then the participants were asked collectively whether the theory as a whole captured the essential elements of their work. At that time, there were already discussions about using the theory to develop performance standards and other information materials about the multicultural health brokers' work.

Memoing

Memoing is a process of recording ideas, questions and musings about a study, particularly during data collection and analysis. Memoing has three purposes: "to make explicit the researcher's assumptions; to record methodological decisions regarding the conduct of the study and to speculate in and analyze the data" (Schreiber, 2000 p.72). Glaser (1978) strongly requires researchers to keep track of their reflections throughout the research process. In particular, tentative concepts and preliminary theories should be recorded to show the progress of theory construction. I kept a personal journal of my thoughts, reflections and sketches of theories in development throughout the research. I found that the best ideas come to me at times when I was not focusing on a specific aspect of the research or when my mind wandered aimlessly. Mays (2000as quoted by Schreiber) acknowledges the importance of the analyst's intuitive process as a conscious and unconscious reflection of the study as a whole in the final stages of theory building. I have constructed about 15 different diagrams of the MCHB practice and narrowed these diagrams down to two models. I used the two models to examine the interview transcripts again and to assess how they could explain the experience of the multicultural health brokers. The same models were also presented in the validation workshop after the multicultural health brokers had undergone the aided theory-building exercise. There were modifications to the original model I had drafted as result of the validation workshop.

Other sources of data

This study referred to the categories of cultural brokering revealed in the works of Jezewski (1989) with migrant farm workers. She has published several articles on cultural brokering across a variety of nursing contexts that have further refined any grounded theory on cultural brokering. Jezewski's continuing work capturing progressive dimensions of cultural brokering has significantly inspired this dissertation in terms of moving the concept of cultural brokering beyond the nurses' experience in the health clinic into a wider arena of the community and health institutions through the experience of non-health professionals.

In addition to the primary source of data (the MCHB interviews) several data sources were used for comparing data. The first one is an evaluation report done on the work of the multicultural health brokers: "Final Evaluation Report for the Culturally Responsive Perinatal and Family Support Project" prepared by Wolfe-Gordon Consulting in 1998. This report generated data on clients' and multicultural health brokers' experiences in multicultural health brokering in the area of perinatal health in immigrant and refugee families. This report was used to look at a historical comparison of past and current practices and is also a comparison of client experiences. It is interesting to note that the emerging categories were also found in the 1998 report. My own personal observations of my participation in the MCHB Co-op as a member and as a colleague were useful in understanding the MCHBs' perspective. A significant contribution to the data was my recent experience of brokering support for a pregnant young woman from my own community.

Part Three
Results

The grounded theory of multicultural health brokering was constructed from data drawn from individual interviews, focus group discussions, personal experience of the researcher and relevant literature. The theory or conceptualization of the practice of multicultural health brokering captures the essential elements of the practice and provides an explanatory framework for the work of the multicultural health brokers.

This section begins with a profile of the research participants and how they became multicultural health brokers. The section also introduces the grounded theory of multicultural health brokering with an overview of the stages and dimensions of the practice. The substantial portion of this chapter is a detailed discussion of the theory of the multicultural health brokering practice including how the constituents of the theory were derived and developed from the data. This process will be illustrated through a Coding Process Table. The Coding Process Table presents excerpts from the interviews, the codes generated from those interviews to show the inductive progression of data, and the concepts and elements of a theory. This is followed by a summative articulation of the multicultural health brokering theory and how this theory informs the delineation of attributes of a multicultural health broker. A section about the Multicultural Health Brokers Co-operative is included as part of the results of the study. This section culminates by identifying the relevance and contributions of the grounded theory of multicultural health brokering in the literature particularly in the areas of social support theory, social work practice, community development and health promotion.

I. The research participants

This section introduces the multicultural health brokers (MCHBs) who participated in the study. The purpose of this introduction is to reveal the personal circumstances and social contexts of the women who are the multicultural health brokers. It was a humbling experience trying to capture the depth and richness of the lives of these participants; their journey from their home countries to the life they have

created in Canada are stories of resiliency of the human spirit overcoming adversities that perhaps many of us may never experience in our lifetime.

A profile of the participants

There were fifteen research participants in this study. The MCHB Co-op has a total of eighteen (18) Co-op members; thirteen (13) participated in the study. Two of the research participants are not MCHB Co-op members but are contracted workers in a project by the MCHB Co-op. All of the research participants are multicultural health brokers. They come from diverse cultural, ethnic and religious backgrounds. Their home countries include Chile, China, Hong Kong, India, Lebanon, Mexico, Pakistan, Somalia, the former Yugoslavia and Vietnam. Their religious backgrounds include Islam, Buddhism, Roman Catholicism, Sikhism and others. They are multilingual; most of them speak an average of three languages in addition to English. The multicultural health brokers' history of immigration reflects many stories of newcomers who came to Canada to seek a better life and to escape war and political upheavals in their home country.

The MCHBs who came here as independent immigrants were brought to Canada by their spouses/fiancés or by family members. Most have lived here for more than twenty years, including three who arrived as young children. Their children were born and raised here in Canada. They have come to like Canada for its peaceful and safe environment, the opportunities it offers that were not available in their home country and the amenities in a Western industrialized society.

> .... it is a safe place to bring the children up, and that was one of the reasons why we live here, and if, you know, the children move to another place for a better future, then we might move, otherwise we are quite happy here. (Participant)

> So far, I like to live in Canada and specially in Edmonton and not anywhere else because it has a sense of living with your identity like a small community, small city. You can practice your religion; you can keep your identity especially being close to the Arabic community. I feel I can raise my kids here by myself although I don't have any extended family. (Participant)

The multicultural health brokers who came here as refugees experienced traumatic escapes from their home countries. Some were part of the first wave of Vietnamese refugees in the US and Canada in the mid-70's after the Vietnam War, and

also then in the 1980s when there was strong anti-Chinese sentiment in Vietnam that resulted in the persecution of Chinese merchants and shopkeepers.

> I have one sister and two brothers who came with me, and we escaped, we came in the boat with the people who do fishing, and we paid each of those 13 gold bars, 13 for each of us. My dad said that we got ripped off by those people. (Participant)

The MCHBs from Vietnam lived in refugee camps for several years before the Canadian government approved their applications for immigration.

> We escaped from the country, so I lived in the Hong Kong concentration camp for eight months with my brother and sister, and then we had another brother and sister who lived here in 1971 sponsor us from the camp to Canada. (Participant)

Although none of the research participants would speak in detail about their lives in the refugee camps, it is well-documented that life in refugee camps was no better than in the boats where many suffered from malnutrition, infectious diseases and maltreatment at the hands of camp guards (Stephenson, 1995).

There are other political events that brought some of the multicultural health brokers to Canada. The military coup in Chile in 1975 and the repressive military regime under General Pinochet brought a steady stream of Chilean refugees into Canada from 1976 until the 1980s not to mention the Civil War in Somalia in 1991 and the Bosnian conflict in 1994. The vestiges of these traumatic experiences are still felt by some of the research participants. For example, some hesitated to have their interviews tape-recorded. Two of the MCHBs preferred to have their interviews written down. In one interview, we had to pause for several minutes because the participant was getting tense and anxious. It has been said that the effects of traumatic experiences are long-lasting and enduring and it takes a great deal of courage and determination to heal the emotional scars and recapture one's strength to face life again (Stephenson, 1995).

Struggles in Canada

Like many newcomers, most of the MCHBs identified the cold Canadian weather as the one thing that scared them when they first arrived here.

> At that time, I thought it was too cold for me. I was scared, nervous. The first day that I arrived here it was wet, in the wintertime. It was November, -20, it was cold. (Participant)

> The only thing I don't like is the long winters. (Participant)

The MCHBs spoke of being isolated and lonely, particularly those who did not have relatives in the new country.

> ... the first year was very lonely for me living in Canada. When I came to Canada, I came to Toronto, Ontario and I had the friends, I was there in Toronto for about three or four months after that, we went to Ferry Sound. I think it is two or three hundred kilometers from Toronto. We were there for roughly a year I think, and that was the loneliest time ever in my life. (Participant)

As well, government-sponsored refugees had to settle in a place that was pre-assigned to them regardless of suitability for the family's experience. For instance, the family of one MCHB was placed in a rural farming community in Saskatchewan in the middle of winter. Back home, the family members were entrepreneurs who owned a business in the capital city. This experience was distressing for the family and demonstrated insensitivity of the newcomer settlement program.

It was not only the unfamiliar physical and social environment that some of the MCHBs had to adapt to, it was also the obvious and glaring change in their life circumstances, particularly their economic status.

> ... we more suffer poverty (here)than at home... because back home we were a rich family and when I moved here, I found myself living in a small house, a small apartment. I never experienced that, or my sister having to work an extra job just to bring money, and then parents later on, we don't want to tell parents that, that they don't have some money, so we still, although my sister's daughters are all grown up, but they still use my parents' money even though they're here, so my parents support us here. (Participant)

This participant's words echo the sentiments of many of the MCHBs particularly those who had to leave their country involuntarily. But the hardest and most painful of all their challenges as immigrants in Canada was coping with the devaluation of their foreign education and work experience. All of the MCHBs have university degrees. Twelve of them obtained their degrees in their home countries while three who grew up here benefited from Canadian education. Comparing their foreign-education and work experience with their Canadian employment history revealed a marked discrepancy between skills and employment. The interviews provided data to track the MCHBs' occupational history starting from their education and work experience in their home country to their employment history in Canada. The occupational history of the foreign-educated MCHBs illustrates the persistent issue of lack of accreditation of foreign

credentials. Until now, this has not been comprehensively addressed by the Canadian government and remains the most significant barrier to the occupational mobility of immigrants and refugees (Galabuzi, 2001; Health Canada, 1999a).

Table 1 presents the occupational history of the research participants prior to their multicultural health brokering work.

Table 1. Occupational History of MCHBs

Home country education	Home country work experience	Canadian employment history (Pre-MCHB)
Library Science (with post-graduate degree)	Recent graduate before coming to Canada	Retail worker; part-time library assistant Nursing aide; Support worker
Statistics	Computer analyst and programmer	Bank employee; volunteer interpreter parenting educator
Communication Arts	Graphic designer	Support staff in hospital Self-employed in graphic design
Education	High school teacher math and physics teacher	Day care corker; ESL teacher Group home worker; real estate salesperson; trade worker eElectrical technician; sewing machine operator); Settlement worker
Nursing	Nurse	Community volunteer
Sociology	Left country after finishing school	Child and family worker; researcher life skills coach; perinatal educator
Law	Lawyer	Settlement worker

* Excludes three MCHBs who grew up and studied in Edmonton.

To the MCHBs, their occupational history reveals a struggle to survive and adapt to what they perceived to be an unreasonable requirements for newcomers finding employment in Canada.

> Professionally, I was not very satisfied, or let's put it this way, I find that, you know, my own qualifications and then the remunerations, that they don't match. Sometimes, I worked in the daycare, you know, that is pretty menial pay, they were very happy to receive me. It was only afterwards, in hindsight that, gee, I look good on their papers, you know, so this worker here has got some qualifications and is working, so it looks good for the daycare itself, (that they have a) highly qualified staff. (Participant)

> Yeah, frustrations sometimes, when you cannot find your work in your own profession... frustrations by learning and trying to capture the best of the culture and keeping the best of your own. (Participant)

> I kept on applying every time they are advertising and they interviewed me three times same group of people and then didn't get the job. But you know they did their job and they called up for interview and so one time I asked that one woman who was in the interview panel, how come you never you know... so they said there was always

somebody better than me competing, and also the easy cop-out was that I'm too qualified... and don't have the Canadian degree. So that was the end of my career. (Participant)

While there were a few participants who had been able to find work that was closer to their education, it was still not the best kind of work that they were qualified for. The search for better employment resulted in switching from one job to another. It is also interesting to note that given their average length of residence (about ten years), most of them had not found stable employment until they became multicultural health brokers in 1992. This is consistent with studies on immigrant employment history, which notes that it takes 12-15 years of residence before a newcomer can achieve job security and catch up with the earnings of the general Canadian population (Basavarajappa & Jones, 1999). The occupational history and mobility of immigrants would be different between first generation and second generation immigrants. Second generation immigrants are children who were born in Canada from immigrant parents as well those who arrived here young enough to be educated in Canada. Their chances for suitable employment are better than those who arrived at their working age. This is shown in this study of two MCHBs who were educated in Alberta and had found jobs suited to their education before they chose to become a multicultural health broker.

A confounding circumstance to the participants' employment was the fact that most of them had to balance both work and family. Since they are women and females in their cultural traditions, they were still expected to carry the burden of parenting and managing the household.

And unfortunately I had to leave my baby daughter with the baby sitter overnight and picked her up on the weekends on my days off. I was doing shift work and I don't have a car and you know I had nobody with me. It was very, very bad experience that I had to leave her with strangers, people I didn't know. That time you know when she became a little older, she used to cry when I leave her because she wanted to go home with me... (Participant)

It was very hard for me with having five kids under ten and working full time. From the early morning, we live in the north and I have to drive all the way to work to the computer. So it was very hard to be full-time mom and a full-time worker and even I was having a big tension in the house because of depression. After a year, I left the work

with the computer. I said I couldn't make it. I'll work part-time and so I work only four months in a bank. After that it was also very hard to do everything by myself and to go out in the new society and to look after the kids and everything on my hands... (Participant)

Becoming a multicultural health broker

The dissatisfaction and anguish in their search for suitable employment left a profound impact on the lives of the MCHBs in Canada. To them, the requirement of a Canadian experience for local employment represented the inequities of Canadian society, particularly towards immigrants and refugees who make up the bulk of ethnic minorities. The employment challenges experienced by the MCHBs is a symbol of the marginalization of ethnic minorities whose only barrier to social and economic mobility is their foreign origin. It was a realization that advancement in Canadian society has less to do with personal abilities and more to do with racial and ethnic origins. Yet it is this same disillusionment that had spurred the MCHBs to create opportunities where their inherent talent and skills and their life experience can be useful to their communities.

Many of the MCHBs worked as community volunteers before they were introduced into multicultural health brokering. Below is a list of the volunteer work they had contributed to ethnic communities:

- Translating health information materials in English into their own languages
- Teaching heritage language to second-generation immigrants in their communities
- Serving on the board of directors of their cultural associations
- Teaching pre-natal classes in their own languages
- Connecting immigrant women to other women in their communities or to resources and services in mainstream service organizations

Their connections with the community provided a natural opportunity for recruiting them to become the first group of multicultural perinatal health educators for the Edmonton Board of Health in 1992. Of the fifteen participants in this research, ten of them belonged to the original group. Their compassionate hearts and love for people predisposed the MCHBs to cultural brokering work. However, their own life experiences as newcomers were the most compelling reason for their commitment to help others in the community because I personally have experienced this, these difficulties, I don't want anybody else to have to go through that. And so, I will use what I remember in terms of the experience and even the feelings, so that I work in a very

> authentic way, but then when you're so involved with the people, and often when you work with your heart, people respond with their hearts, and so you have really, a real relationship emerging. (Participant)

> It is very rewarding to help people. Especially if you know what it is like to be in their shoes. We were once in the same boat- the war, and refugee camps. I know the immigrant experience and that makes it easier for me to understand and help. To best help someone, I need to understand his or her problem. (Participant)

When asked about what they like about their work as multicultural health brokers, many of the participants said that their greatest reward from the work is when they watch the babies they have seen through their pre-natal classes grow up healthy.

> I think it is very rewarding because we know the moms, when they are still pregnant, now the kids are growing, and you see them learning something from our drop-in, because we can see the big difference that the kids make, they learn to be social with other kids, listen to their teacher, things like that. (Participant)

Many of the participants are most happy when they are with these families.

> ... the most joyful moment is being with the families. I am happy when I see the people can be independent, when I know that the person knows something and then they can do by themselves. (Participant)

In the last five years as multicultural health brokers, three MCHB participants in the study have found suitable and stable employment outside of the Co-op. As MCHBs, they were able to find the right connections and prove themselves capable for the position for which they were hired. Those who are currently working in the Co-op's projects have finally found a place they can call their own. In multicultural health brokering work, cultural backgrounds and the immigrant experience seem to outweigh the requirement of a Canadian experience to find employment. The MCHB participants also enjoy the freedom to make the most of their talent and skills.

> I like the work that I do, it gives me a lot of satisfaction when I've made a difference. I'm valued in the community, I get people telling me that 'Oh the radio program is really good'. (Participant)

> That I can see the improvements in their life, that's really big for me, because I feel not because my work is very good, but also the feeling that these people appreciate what I'm doing. It's not that I'm looking for a present or anything like that, just I see them happy and they say, "Thank you". That's all. (Participant)

The feeling of being valued and appreciated can be very important, especially when one has struggled over the years to gain recognition of one's abilities. This validates Wilkinson's (2001) studies of self-esteem as an indicator of health. In his study, pride, dignity and respect are critical determinants of personal health. According to Wilkinson (200), these indicators are rooted in structural conditions of equality; not only material wealth but also social status. This observation supports studies relating to the impact on the personal health of women who work as community health workers (CHWs). These studies indicate that increased knowledge and skills and improvement of self-esteem are benefits enjoyed by the CHWs (Booker, Bonnie, Najera, & Stewart, 1997). The most rewarding benefit of all is personal transformation. Booker (1997) noted that " the feeling of being capable of helping others is critical to being able to assist others to make decisions about their own health" (p.12). Roman (1999) viewed this as a health promotion opportunity to the CHWs as they gained greater confidence in their capacity to control their own lives.

The story of how the multicultural health brokers got organized as a group would not be complete without mentioning one research participant who to this day remains the singular factor for bringing them together, nurturing their strengths and sustaining the growth and life of the MCHB Co-op. All fourteen participants mentioned her name as the one who had found them, and together with her they created the organization of multicultural health brokers. She exemplifies hope in the midst of adversity and marginalization, and she gave the MCHBs a gift that brought back belief in themselves. She recruited the MCHBs into the multicultural perinatal health program, secured consistent funding to support their work and later steered the group into forming a workers' co-operative. Although she remains humble about her achievements and unceasingly attributes the Co-op's success to its members, she is the catalyst in the organization.

The sixteenth participant: Integrating insider and outsider roles

My interest in pursuing a study that is rooted in issues of equity and social justice comes from my own experience growing up in a country where wide disparities

in wealth and income and limited opportunities for mobility and advancement plagued those who lack economic and social influence. My experience has led me to a profession in rural development in the Philippines, working with peasants, rural women and fisherfolks for almost two decades. Through this work I drew inspiration and energy from the genuine and relentless desire of people and communities to shape their own development. It was dispiriting, however, to accept the reality that economic, social and political structures of inequality and oppression exist, often hindering opportunities for people to achieve real and lasting improvement in their lives. My work experience in the Philippines has been an overwhelming influence in shaping my view of the world from a lens of equity and social justice. Thus, I am incessantly drawn to issues around people disempowered by historical, political, economic and social forces, in addition to desiring processes that nurture shared learning and collective knowledge development.

The idea of pursuing my thesis on cultural brokering based on the experience of the MCHBs developed in a conversation with my friend and colleague who founded, led and sustained the work of the multicultural health brokers. She was concerned that their workload had increased through the years, leaving them very little time to reflect as a collective, and thus, they were missing opportunities to examine their work, to learn and improve their practice. Sometimes the struggle to survive (they too have their own families) and support others is so overwhelming that taking time to be reflective would seem a luxury for them; I offered my help through this research to create that very opportunity. I have worked with the multicultural health brokers for three years in a supportive role. I have helped them write project proposals, served as a resource person in their participatory research project and community development work and co-coordinated one of their projects.

Perhaps I could make a contribution towards their pursuit to find recognition for their work as an outcome of this research. I could help them define their practice so that it will be understood, appreciated and supported by service providers, decision-makers and members of their own community. At this point, I was stepping into the "researcher role" – the traditional outsider bringing a set of knowledge and skills into the research process. This is Lucenia's research, the multicultural health brokers would often say. There was a feeling of ambiguity as I explored the duality of my role: the

outsider/researcher and insider/colleague. I felt that there should be no struggle in performing these roles since the outcome would ultimately be directed to the best interests of the multicultural health brokers. My relationship with the MCHBs as a colleague, friend and advocate is intimately woven into the research process.

My personal perspective, influenced largely by my working relationship with the MCHBs, was reflected in my organizing the research process, in structuring the process of data collection and analysis and in integrating my own insights in the final synthesis of the data. For example, the participatory processes adopted in the research from planning the research to the validation of research findings are examples of my belief in people's capacities. Making decisions about the research was always a democratic process involving those who are affected by the research. I was comfortable sharing power with the research participants, knowing that they possess knowledge and skills that are equally important to my own academic research skills.

Since February 2000, when the MCHBs first framed our research question up to the time I had facilitated the first focus group, I knew that I was clearly the researcher. Since I was not providing direct services to individuals and communities and was helping them with organizational work, I felt as an outsider looking in until late November 2001.

At that time, I received a referral from a multicultural health broker about a young woman from my community who was pregnant and unmarried. She was close to delivery, barely seven months in Canada, with no relatives or friends here. Since I did not have formal training in providing pre-natal education, I asked a multicultural health broker who belonged to my ethnic community to work with me on the young woman's pre-natal needs. When we visited the young woman for the first time, I focused on gathering information about her situation using a mental checklist of what would constitute a cultural assessment tool. This included her personal information, immigration history, family relationships back home, social support etc. I asked her how she perceived her current situation and how she would deal with it. The other multicultural health broker helped her with her pre-natal needs. I was overwhelmed at the complexity of her problems, particularly her precarious immigration status, the coming baby and the woman's limited social support. There were so many interrelated

issues to deal with including her family situation in her home country. We focused on responding to the immediate needs first – securing support for her delivery and temporary housing after she delivered. The public health nurse phoned me after her delivery to express her concern about the ongoing support for the mother and the baby including a permanent place to live. During the holiday season, I spent most of my time trying to allay her feelings of hopelessness, making connections for available support for her including housing and future employment, as well as making sure that she stayed healthy at this critical time when her baby needed her. What was most difficult at that time was that most of the service agencies were closed from Christmas until the New Year, including immigrant-serving agencies. Together with my colleague, we had to make use of our community connections to access support for her. Little did I realize at that time that I was functioning as a multicultural health broker at the front-line!

We were able to find the young woman suitable housing, employment options and we connected her with her sister in the United States who would be helping her financially. She is still struggling at this time, especially with motherhood and limited resources, but with a sense of hopefulness that things will get better someday. I learned that a multicultural health broker's work is never really done in a "case/file closed" sense. She is someone whom I know I will meet again in my community and whom I will think of once in a while. I have also realized that the practical supports that were available for the client were most significant in building relationships with the clients. These are the smallest things: answering phone calls at odd hours, being available to listen, arranging appointments, driving them to the clinic and making sure that their needs, however trivial, are attended to. Yet these smallest of things seemed to make the difference in achieving the best outcomes, especially when the other person is in the midst of despair and hopelessness.

When I sat down to examine my data after the experience, I could not help but identify with many of the stories the multicultural health brokers told me in the interviews. Suddenly I knew and felt what they were talking about. I felt a deep sense of bonding with my research participants. I was in fact now a research participant.

With this experience, I realized what the ambiguity of roles really meant. Many questions bothered me. Is there really a distinction between myself as the

outsider/researcher or the insider/participant? I knew that this experience would influence my analysis of the data. I asked myself, would this experience increase or diminish my theoretical sensitivity?

Within sociological traditions, Bartunek and Louis (1996) cited Merton and Schultz (1996) in distinguishing insider and outsider roles. According to Merton and Schultz (1996), outsiders (sociologists) are the disinterested scientific onlookers of the social world, using skills in observing, describing and classifying the social world according to scientific ideals. The outsider is objective (Merton & Schultz, 1996). The insider is the actor in the social world and organizes his/her knowledge according to what is relevant to him/her. The insider is subjective (Merton & Schultz, 1996). The reason for this distinction is a concern about tainting the data with insider bias because of the presumption that an insider has the best access to knowledge about the social world being studied. For example, when someone is an immigrant woman, she knows how it feels to be one and therefore may use that to frame someone else's experience.

Many researchers disagree with this view presented by Merton and Schultz (1996). For example, Aguilar (1985) explains that bias is the human condition that presents a danger for both insider and outsider researchers: "A lack of unfailing commitment to objectivity is not a quality exclusive to insider researchers in general" (Aguilar, 1985 ,p.23). Ratcliffe and Gonzales (1988) enlighten us about the illusion of scientific rigor (the notion that a scientific and rigorous research must remain neutral and objective of the researcher's personal orientations) in research as a means of protecting the researcher as well as the collection and analysis of data from bias. Research, whether qualitative or quantitative, is not entirely independent of researchers and their values. The choice of research interest, the framing of the research question, methodological orientation and data interpretation, will reflect the researcher's philosophical and theoretical assumptions that come from his/her values and view of the world. Ratcliffe and Gonzales (1988) suggest exploring an expanded concept of rigor that takes into account the interaction of the researcher with the research process and thus helps to understand the research within the context of the values and commitment of the researcher. Insider research opens opportunities not only to provide information

about the groups involved in the research but also about the insider researchers themselves.

Bartunek and Louis (1996) citing Kelly et al (1993) espouse an ecological approach to research where collaboration is central to the research process. This collaboration is based on recognizing the value of bringing together an outsider's view of the world and the insider's experience in that world. The collaboration is an outcome of defining a working relationship between the researcher and the participants and is expected to increase the authenticity, validity and usefulness of the research. For instance, some advocates of participatory action research (PAR) do not even make a distinction between researcher and participants. In PAR, everyone involved in the research are all researchers and learners engaged in the process of seeking and developing knowledge together (Deshler & Ewert, 2000).

Bartunek and Louis (1996) offered an alternative perspective, which is for the researcher - regardless of whether she or he is an insider or outsider - to adopt a marginal stance. This perspective suggests positioning oneself at the juncture or intersection of the insider and outsider perspective and "leveraging a relative connectedness" to the setting of the research. To be able to do this, the researcher needs a partner to provide the other contrasting view, whether it is the insider or outsider view, and to constantly reflect on maintaining sound research practices. Having the opportunities to see things in two realms increases the researcher's sensitivity to discovering new ideas.

Grounded theorists who have adopted an integrated constructivist and feminist paradigm would find congruence in Bartunek and Louis' perspective. Mallory (2001) referred to Robrecht's view which states that the investigator's subjective reality is as important as the informant's experience. While the informant may provide the experiential knowledge through the data gathered, the grounded theory analyst interacts with the data and influences the determination of elements that are significant or salient. Building on Bartunek and Louis, Mallory (2001) suggested another strategy called the analysis of difference through self-examination. She urged researchers who are also insiders in the research process to undergo continuing self-assessment and to be aware how one's own values, beliefs, power and experience can filter or colour the

interpretation of data. Mallory (2001) called this informed speculation wherein the researcher assesses how his/her own values and beliefs may be different or similar from those of the research participants and how these differences affect the outcome of the research. Once these differences are known, the researcher negotiates with the research participants in drawing similar shared concepts. This is what Mallory (2001) labelled the co-construction of reality.

In this study, I adopted Mallory's approach of co-construction of reality because of the dual role that I now have in the research, that of an outsider and an insider. I kept a journal of my own experience so I could constantly reflect on my actions in relation to this research. Working with the young woman reminded me that I was performing a dual role of research participant/insider and experienced for myself a dimension of the multicultural health brokering practice. I was also the researcher/outsider who attempted to analyze my own experience as the other participants' experience, hoping that it will contribute to the study. I also conceptualized my individual experience and kept it in the background until the research participants had reached the conceptualization stage. I was conscious too that as the facilitator of the collective analytical process, I had influence in organizing how the analysis would proceed. The strategy I used to ensure that the analysis was done with sensitivity and maximum participation from the multicultural health brokers was to simulate the analytical process during the focus groups. The process we used for deriving the categories would be no different from what I would have experienced as an individual analyst. There were challenges, of course, such as arriving at a consensus and finding the appropriate words or terms for conceptualizing ideas since all of us speak English as a second language. In the end, we were quite pleased with this initial conceptualization effort. From a researcher's perspective, I was confident that it was a respectful process for the multicultural health brokers to arrive at a first theoretical abstraction of their practice. The details about this collaborative process are further discussed in the Methods chapter.

Kearney (2001) recognizes the power of investigators over participants and the data they provide. Most often this power is not easily visible from the prompts the

researcher used in eliciting data to the organization and presentation of the data. She recommends that researchers must reveal their standpoint at the beginning of the research to sensitize the reader to a particular shaping and treatment of the data. Because "findings do not float free of objective truth independent of their origins" (Kearney, 1995 citing Thorne, 1995, p. 242), grounded theorists are interpreters regardless of their theoretical and personal bias. In this section, I have explicitly stated my standpoint as someone whose search for knowledge is driven by issues of oppression, powerlessness and injustice. Power sharing and democratic processes are important in the way I work with people. This study documented the processes I have created while engaging research participants in a meaningful search for knowledge and these processes will be demonstrated in the subsequent chapters.

II. Multicultural health brokering as a basic social process

Multicultural health brokering fits what Glaser (1978) calls the Basic Social Process. The Basic Social Process (BSP) is one type of core category within grounded theory where the theory emanates (Alvesson & Skoldberg, 2000). A BSP is "processural in nature that has two or more emergent stages" (Glaser, 1978p. 96). As a process, BSP's occurs over time and involves changes over time. BSPs are identifiable by gerund or words ending in *-ing*. The use of gerunds is intended to demonstrate a temporal nature and to represent acts or actions of participants in the process.

While multicultural health brokering is a pre-existent category (the sensitizing concept in the study) the theoretical coding evolved a Basic Social Process. The resulting grounded theory consists of multiple stages occurring over time with a point of initiation (beginning) and resolution (ending). The stages occur in a progression, where each stage is a preceding condition of the next stage until the process reaches its resolution.

III. Overview of the grounded theory of multicultural health brokering

The multicultural health brokering practice is a theory of stages and dimensions. The stages and dimensions emerged from the data as categories. Multicultural health brokering in this study has four stages (categories): initiation, building connectedness,

brokering support and achieving equity of access to health. These stages occur in a sequential and logical progression starting from initiation to a point of resolution, which is achieving equity of access to health. Some stages may overlap with each other because of the complexity of the problems being dealt with, as well as the dynamic nature of working with people and communities sometimes necessitates going back and forth between stages when new issues emerge during the process of intervention. Each of the stages has specific properties or attributes that are also embedded in the different dimensions of the practice.

Multicultural health brokering is a multi-dimensional practice. The study revealed four dimensions in the multicultural health brokering practice. These dimensions are focal areas of work within the stages of the multicultural health practice. These dimensions may happen all at the same time, but there may be times when one dimension is emphasized over another depending on specific conditions and specific circumstances operating at any one time. These dimensions provide one-on-one support to ethnic minority individuals and families, build supportive groups in ethnic minority communities, build a community's capacity for self-determination and catalyze institutional change towards cultural competence.

There are three key participants involved in the practice of multicultural health brokering: the client, defined as the individual, family, group or community who is experiencing or struggling with a problematic condition; the service providers, such as individuals, institutions and systems who have power and control over resources and opportunities; and the multicultural health broker who is the primary actor in engaging the first two participants in the act of resolving a problematic condition.

Figure 7 illustrates the relationships of categories within the stages and dimensions of the multicultural health brokering practice.

Figure 7 **Multicultural Health Brokering: Properties of Stages and Dimensions of Practice**

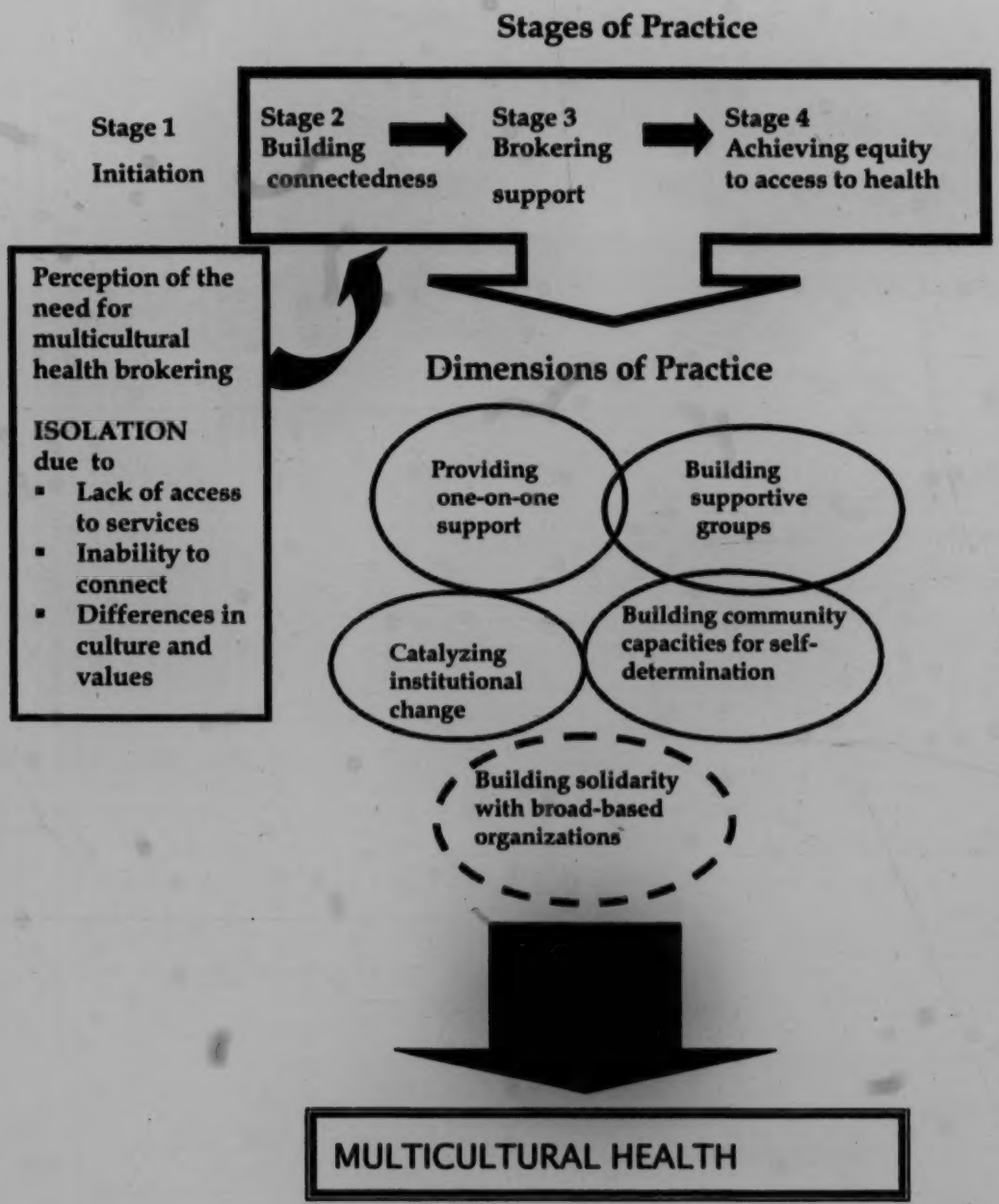


Table 2 summarizes the shared properties of the stages and dimensions of the grounded theory of the multicultural health brokering practice.

Table 2. Multicultural Health Brokering: Properties of Stages and Dimensions of Practice

Dimensions	Stages		
	Building connectedness (Properties)	**Brokering support (Properties)**	**Achieving equity of access to health (Properties)**
Providing one-on-one support to ethnic minority individuals and families	▪ Empathetic[4] and reflective listening ▪ Creating trusting relationships	▪ Generating holistic and critical knowledge about health issues and life circumstances ▪ Bridging/ mediating different cultural perspectives and understandings ▪ Connecting families to relevant resources to meet their needs ▪ Advocating for the less powerful and the marginalized	**Short-term outcomes** ▪ Access to services for promoting & maintaining health ▪ Resolution of present or immediate issues **Long- term outcomes** ▪ Becoming autonomous, independent and empowered ▪ Beginning to address underlying or deeper issues
Building supportive groups in ethnic minority communities	▪ Finding common needs and interests ▪ Creating a sense of togetherness	▪ Creatively responding to progressive needs and concerns ▪ Leveraging support for group needs	▪ Increased opportunities for social interaction ▪ Access to resources for group dev't. ▪ Feelings of self-worth

[4] Empathetic – (adj.) showing empathy or ready comprehension of others' states. American Heritage Dictionary (2000). Fourth Edition. Houghton Muffin Company. First introduced in 1932. Also cited by Cambridge International Dictionary of English (2000) & American Merriam Webster Dictionary, 2000.

Table 2. Continued

Dimensions	Stages		
	Building connectedness (Properties)	Brokering support (Properties)	Achieving equity of access to health (Properties
Building a community's capacity for self-determination	Creating a sense of "community" or collectiveness	▪ Partnering with indigenous leaders to act on community issues ▪ Connecting communities with service providers and institutions ▪ Collaborating with community organizations to address community concerns ▪ Mobilizing community action in culturally responsive ways	▪ Increasing community access to opportunities for well-being ▪ Collective sense of being valued
Catalyzing institutional change	Nurturing a relationship with "champions" and allies within institutions	▪ Articulating the issues and struggles of ethnic minority communities ▪ Enabling service providers to become culturally competent ▪ Advocating for changes in the system ▪ Helping institutions to be responsive to cultural diversity	▪ Institutions recognizing needs of ethnic minorities ▪ Improving service to meet diverse needs ▪ Service organizations open to a community's way of doing ("a sense of community development")

Stages of the multicultural health brokering practice

This section provides an overview of the stages and dimensions of the multicultural health brokering practice and how they relate with each other to constitute a theory. Each stage in the multicultural health brokering process will be discussed as they proceed from the initiation (Stage 1) to achieving equity of access to health (Stage 4). Each dimension will also be explained briefly. The details of the properties of each stage and dimension will be discussed in the subsequent section, with examples.

Initiation is Stage 1 of the grounded theory of multicultural health brokering. Initiation is the first category and indicates the need for multicultural health brokering.

Isolation is the only property in this category and it is the primary condition by which multicultural health brokering is initiated. Isolation describes the adaptational experience of ethnic minority individuals, families and communities as newcomers. Isolation is manifested in the lack of access to supportive resources and opportunities for health and well-being. Isolation also means people's inability to connect with others within and outside of their community. Isolation can also result when there are differences in culture and values between the people and service providers, or between communities and institutions.

> I know that a lot of these new mothers are usually new from India; they are not familiar with the way the health care system works in Canada, or let's say in Edmonton, and they're unaware of the services which they more than likely access which they have no idea that they can access those services. In many cases, these new mothers are also isolated, very lonely, so much so that when they come here, they get married to a young man from Edmonton. This young man and his family might be living in Edmonton for the past 10 or 15 years, but since they have not had any young women deliver in the family, even the family has no idea of all the services, and of all the conveniences or what is available here for Canada for new moms who have delivered recently. (Participant)

> Like for instance with post-natal support, mainly we were talking about dietary support like what they are going to eat during post-natal, that is quite culturally biased and the nurse don't know it. Some of them of the nurse had some good knowledge about those things but because of the language, they really cannot support the family well. Also we said before because of their friend's experience, they know that they can seek advice and they can ask help so they come to us. (Participant)

> Sometimes they don't know where to go... sometimes because of the language even though they know which agencies they can't help them. (Participant)

Building connectedness is Stage 2. It is the first step to immediately addressing isolation in the multicultural brokering practice. Building connectedness means creating meaningful connections through shared language, shared cultures and shared experiences (Wolfe-Gordon Consulting, 1998). Multicultural health brokering creates a situation where language is not a barrier to the unbridled expression of thoughts and feelings. Shared cultures are critical to the surfacing of cultural cues and insights that could promote a better understanding of either people's concerns or barriers they are experiencing and the most appropriate way to respond. Shared experiences provide a grounding context for deepening the initial encounter and a starting point in connecting people with others. Building connectedness is finding the "commonness" between people, groups, communities and institutions that creates and nurtures relationships

. This "commonness" can evolve from shared ideals and aspirations that connect people together to work for change. From the data, seven properties of this category expressed in each of the dimensions of multicultural health brokering were defined as shown in Table 3.

Table 3. Properties of Building Connectedness (Stage 2) Across Dimensions

Dimension category	Properties
Providing one-on-one support	1. Listening with empathy 2. Listening reflectively 3. Creating trusting relationships
Building supportive groups	4. Finding common interests 5. Creating a senses of togetherness
Building community capacities for self-determination	6. Creating a sense of "community" or collectiveness
Catalyzing institutional change	7. Nurturing a relationship with "champions" and allies within institutions

Brokering support is Stage 3. This is a category that captures a set of processes for mobilizing support to address isolation, particularly when the actors involved come from two sets of differing realities. These realities consist of worldviews, values and beliefs, cultural experiences and power relations. These realities oftentimes are in tension or conflict with each other. The key assumption in brokering support is that one of the actors has more power than the other. This is a reality of societies that are hierarchical and unequal in terms of economic advantage, social status and political influence. In multicultural health brokering, supportive linkages are obtained for people, groups and communities who have less power.

> It's very much about someone who knows two sets of cultures, or two ways of looking at things, or two realities, and being able to reveal it to each other. But in this case, the two sides aren't really equal. One side has more power than the other. And so in the mediation is more than bring equal understanding. It's almost, there is an element of advocacy or encouraging the side with more power to let go and recognize they need to accommodate, they need to respond to the other side that has less power. In this case, whether it's working with the community, with the system, or family with a social worker, it's very much about being in that in-between space, bringing people together,

mediating, negotiating, but always the stronger emphasis is on the side of the community or the family that they are the ones that are disadvantaged. Their perspectives need to be raised more so than the system's. (Participant)

The processes involved in brokering support are attributes of how multicultural health brokering moves the problematic situation (isolation) to a point of resolution through supportive linkages. There are 12 properties in this category, all occurring in the different dimensions as shown in Table 4.

Table 4 Properties of Brokering Support (Stage 3) Across Dimensions

Dimension category	Properties
Providing one-on-one support	1. Generating holistic and critical knowledge 2. Bridging/mediation between differing cultural perspectives 3. Connecting to relevant resources 4. Advocating for supportive resources
Building supportive groups	5. Creatively responding to progressive needs and concerns 6. Leveraging support for group needs
Building a community's capacity for self-determination	7. Partnering with indigenous leaders and community organizations to act on common issues and concerns
Building a community's capacity for self-determination	8. Connecting communities to institutions 9. Mobilizing community action in culturally appropriate way
Catalyzing institutional change	10. Articulating the issues of the less powerful 11. Enabling service providers to become culturally competent 12. Advocating for changes within the system

Achieving equity of access to health is Stage 4. This is an outcome category of multicultural health brokering, resulting from actions in the previous stages. This category emerged from the data as a range of outcomes encompassing the ability of individuals, families, groups and communities to access resources and to work towards resolving underlying issues affecting health in general and isolation in particular. The concept of equity of access to health assumes that certain populations have barriers accessing resources for health and well-being. The properties emerging from the data in this category refer to reducing barriers that are specific to individual, group and community experience, but they also exist within a social context that perpetuates the very conditions creating these barriers. The social context is defined not only by

material features such as economic status, but also the hidden and unconscious processes embedded in dominant ideologies and power relations. In other words, the health of ethnic minorities may be compromised by a lack of material resources such as poverty, but their health is further impacted by their inability to speak and act for themselves in a society that has consciously or unconsciously relegated them to the invisible and non-existent. Achieving equity of access to health as an outcome of multicultural health brokering is a direct action towards resolving isolation, a problematic situation that captures the individual barriers and the social context that hinder the attainment of health and well-being. The category of achieving equity of access to health has twelve properties across the four dimensions of multicultural health brokering, as shown in Table 5.

Table 5 Properties of Achieving Equity of Access to Health (Stage 4) Across Dimensions

Dimension category	Properties
Providing one-on-one support	**Short-term outcomes** 1. Access to services for promoting & maintaining health 2. Resolution of present or immediate issues
	Long- term outcomes 3. Becoming autonomous and independent and empowered 4. Beginning to address underlying or deeper issues
Building supportive groups	5. Increased opportunities for social interaction
Building a community's capacity for self-determination	6. Increasing community access to opportunities for well being 7. Collective sense of being valued
Catalyzing institutional change	8. Institutions recognizing needs of ethnic minorities 9. Improving service to meet diverse needs 10. Service organizations open to communities' way of doing ("a sense of community development")

Dimensions of multicultural health brokering

The dimensions or focal areas of work of multicultural health brokering reveal a

multi-dimensional practice that is an inevitable response to the complexity of working around issues of health inequities. The multidimensionality of the multicultural health brokering practice is revealed in the following statement:

> If I were asked today what do I do for a living and I would say I'm a health broker, then I would say we are community workers working with immigrant families, but we don't just provide one-to-one care. As a health broker we also look at supporting our community to develop itself and we also have a mandate around helping the system change so that they become more responsive. And so I've tried to touch upon the levels of work, whereas I'm sure most of my colleagues will speak more about the one-to-one work, right. But as an organization, the health brokering practice, it is meant to be multi-faceted, but also multi-leveled, so that it deals not only with, on a micro-level with each family, it does look at building communities and at the same time it's an ambitious promise, which is to support the systems to change too. (Participant)

The properties arising from the data makes visible individual issues or issues at the micro-level, but also layers of contextual factors impacting these individual issues. The literature on immigrant and refugee health discussed in the first chapter emphasized the contextual factors that affect the health and well-being of ethnic minorities such as lack of access to suitable employment, loss of social support and poverty. These factors are rooted in flaws in social policy development and implementation.

Multicultural health brokering involves being attentive to the total circumstances of the individual and family, not just the immediate or present issues. This holistic approach allows the assessment of broader and deeper issues that are affecting how a family functions. For example, post-natal support is not limited to identifying health education needs, but also to revealing other important factors such as the pregnant woman's immigration experience, family relationships, economic circumstances and social connections. This is important in determining and mobilizing support for the family not only to respond to the immediate issues but also to ensure that key determinants of the present issues are also being addressed. Because of this, it is inevitable that any multicultural health brokering work must extend to the community. The act of connecting people to resources inherently involves linking with supportive networks within their community. If these are not available, the multicultural health broker sometimes assumes the task of organizing such supports. A community too may identify issues of pressing concern for its members, and the multicultural health broker

is often asked to help people work through the issues and find the appropriate response to these issues. In unraveling issues affecting individual, family and community health and well-being, the process of generative inquiry most often leads to systemic issues rooted in policies of institutions or even deeper, into the fundamental structures of society itself. The multicultural health broker serves as a mediator between community and institutions; a broker for obtaining resources from institutions and an advocate and catalyst for changes in the system. The complexity and depth of issues necessitate that multicultural health brokering explores strategies directed at different levels of the public service systems and at multiple arenas. The four dimensions of multicultural health brokering are: providing one-on-one support, building supportive groups, building a community's capacity for self-determination and catalyzing institutional change.

Regardless of whichever dimension of work the MCHBs are currently engaged in, their reasons for initiating the practice revolve around the issue of isolation due to lack of access, inability to connect and differences in cultures and values between ethnic minorities and the mainstream formal system. The four stages of multicultural health brokering remain consistent throughout the four dimensions of the practice but are expressed differently depending on the context and circumstances. The four dimensions have attributes that relate to the different stages of the multicultural health brokering practice.

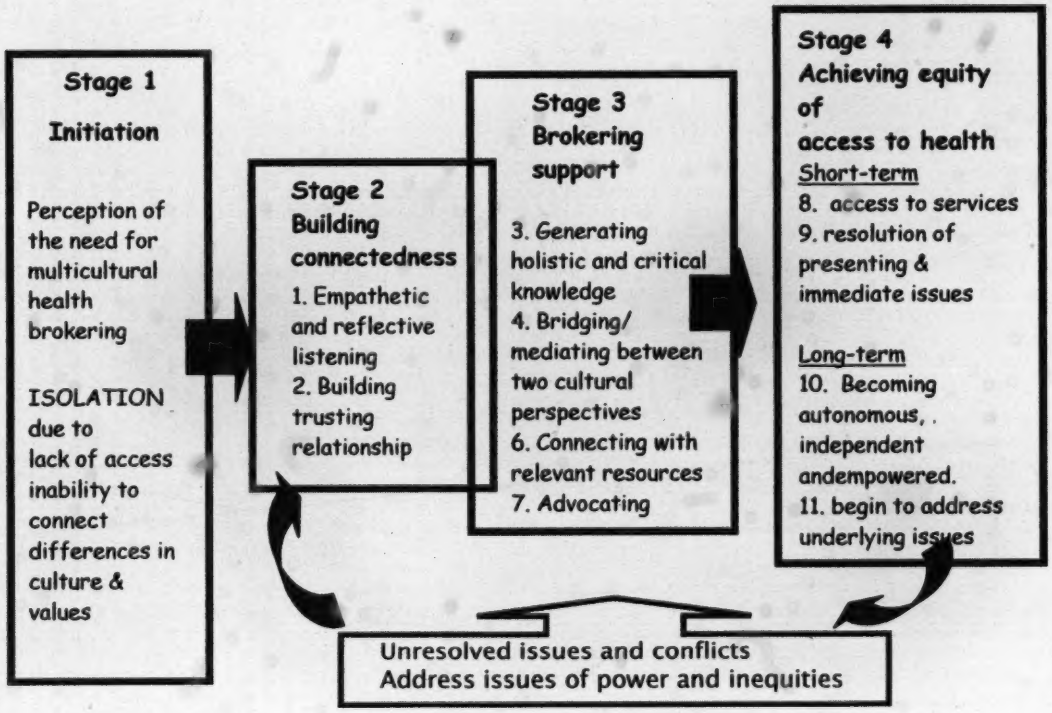
Dimension category 1: Providing one-on-one support

Multicultural health brokering involves providing one-on-one support to individuals and families to assist them in gaining access to and navigating the complex web of the health system and related institutions. As a concept within the multicultural health brokering theory, this dimension keeps the practice grounded in the concrete realities of individuals and families. Without this grounding, multicultural health brokering would lose its relevance in the community. The practice itself will be isolated from the struggle of individuals and families who seek redress from the conditions of inequity. At the individual health encounter between clients and health service providers, multicultural health brokering involves facilitating a deeper understanding of

the cultural context of health and social issues that increases the health providers' responsiveness and sensitivity to the circumstances of individuals of a differing culture. This increased sensitivity will allow the service provider to render interventions that are respectful of the individual's culture and are also attentive to the total context of the presenting issues. The multicultural health broker is the people's first line of support because he/she is accessible, familiar and non-threatening. The brokering support covers a wide range of health and social issues – pre-natal and post-partum care, family violence, child safety, family relationships, isolation and mental health. The arena of support is also varied – mostly in homes and clinics, social services offices, temples and mosques, police stations and courthouses.

The dimension of providing one-on-one support has eleven properties across the stages of multicultural health brokering as shown in Figure 8.

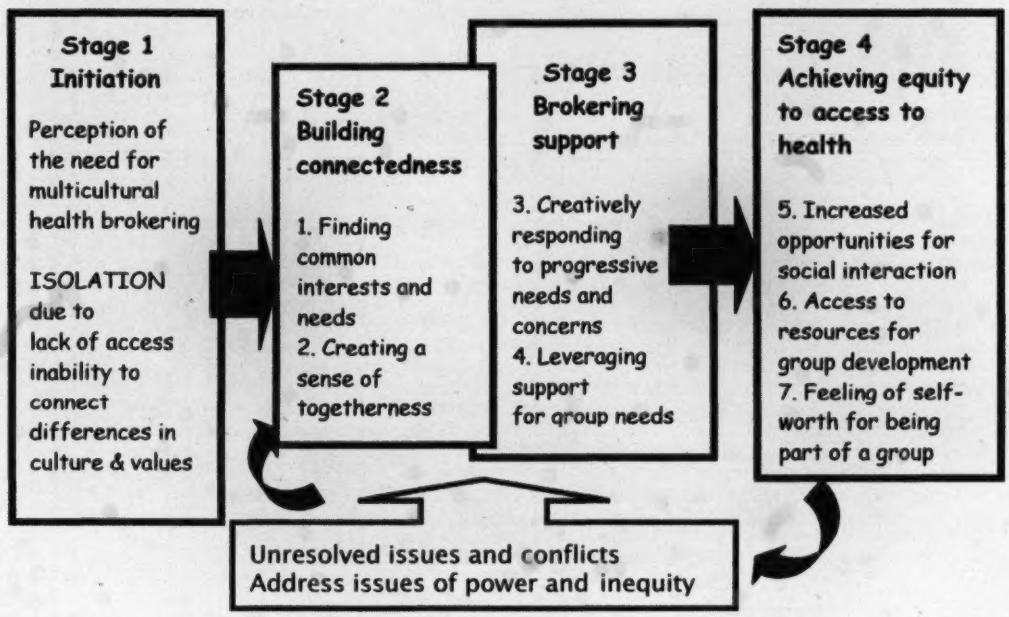
Figure 8 Providing One-on-One Support Within Stages of the MCHB Practice


Stage 1
Initiation
Perception of the need for multicultural health brokering
ISOLATION due to lack of access inability to connect differences in culture & values
Stage 2
Building connectedness
1. Empathetic and reflective listening
2. Building trusting relationship
Stage 3
Brokering support
3. Generating holistic and critical knowledge
4. Bridging/ mediating between two cultural perspectives
6. Connecting with relevant resources
7. Advocating
Stage 4
Achieving equity of access to health
Short-term
8. access to services
9. resolution of presenting & immediate issues
Long-term
10. Becoming autonomous, . independent andempowered.
11. begin to address underlying issues
Unresolved issues and conflicts
Address issues of power and inequities

Dimension category 2: Building supportive groups

Building supportive groups is a dimension category that moves the isolated individual, family and/or community to a place of connectedness with a sense of belonging. It emanates from common concerns, shared interests and the inherent human need to seek out others, particularly others who are also in situations of loneliness and isolation. Building supportive groups creates opportunities where people can be together and work in concert with others on responding to common concerns, fostering common interests and creating relationships. It also nurtures an environment for developing relationships among equals, where people are treated with care and respect and where their gifts are as important as their needs. Building supportive groups is founded on mutual sharing of individual capacities to achieve the group's goal, collectively determining the purpose and growth of the group; and respecting individual needs. Supportive groups are a form of shared power among individuals who may feel that they are not in control of their lives. This is particularly true of immigrants and refugees who must start anew, struggling to comprehend the unfairness of being devalued despite the talents and skills that they bring into this country. Building supportive groups promotes education around practical needs but it is also an arena where the seeds of social change can begin to grow.

Figure 9 Building Supportive Groups Within Stages of the MCHB Practice


Stage 1
Initiation
Perception of the need for multicultural health brokering
ISOLATION due to lack of access inability to connect differences in culture & values
Stage 2
Building connectedness
1. Finding common interests and needs
2. Creating a sense of togetherness
Stage 3
Brokering support
3. Creatively responding to progressive needs and concerns
4. Leveraging support for group needs
Stage 4
Achieving equity to access to health
5. Increased opportunities for social interaction
6. Access to resources for group development
7. Feeling of self-worth for being part of a group
Unresolved issues and conflicts
Address issues of power and inequity

Dimension category 3: Building a community capacity's for self-determination

The third dimension of the multicultural health brokering practice is building a community's capacity for self-determination. In this category, there are two important concepts that must be defined to understand why the multicultural health brokering practice operates at the level of the community. The first is the concept of an ethnic minority community. The study identified ethnic minority communities as the locus of the multicultural health brokering practice. These communities are identified based on shared features such as countries of origin, language, cultural heritage, religion and immigration history into Canada. There is also another facet of an ethnic minority community that underpins the practice of multicultural health brokering; the definition of ethnic minorities on the basis of social status and social relationships. This definition regards the emergence of ethnic minorities as a consequence of unequal relationships in society that divide populations into majority and minority. The basis for such division not only rests on population numbers, but on the relative status and the relationship of the majority to the minority. Concretely, it speaks about the dominance of the Caucasian majority in major societal functions of decision-making and the non-Caucasian minority who have limited access to same. Limited access to vital societal decision-making processes by ethnic minority communities is a consequence of their lower social status in society, limited material resources and lack of tools to engage in and influence the decision-making process (Galabuzi, 2001). As such, ethnic minorities are often objects of change or else are passive recipients of services from institutions. They become targets of programs and consumers of services, and users of new products of which they have little or no participation in how they were developed and designed.

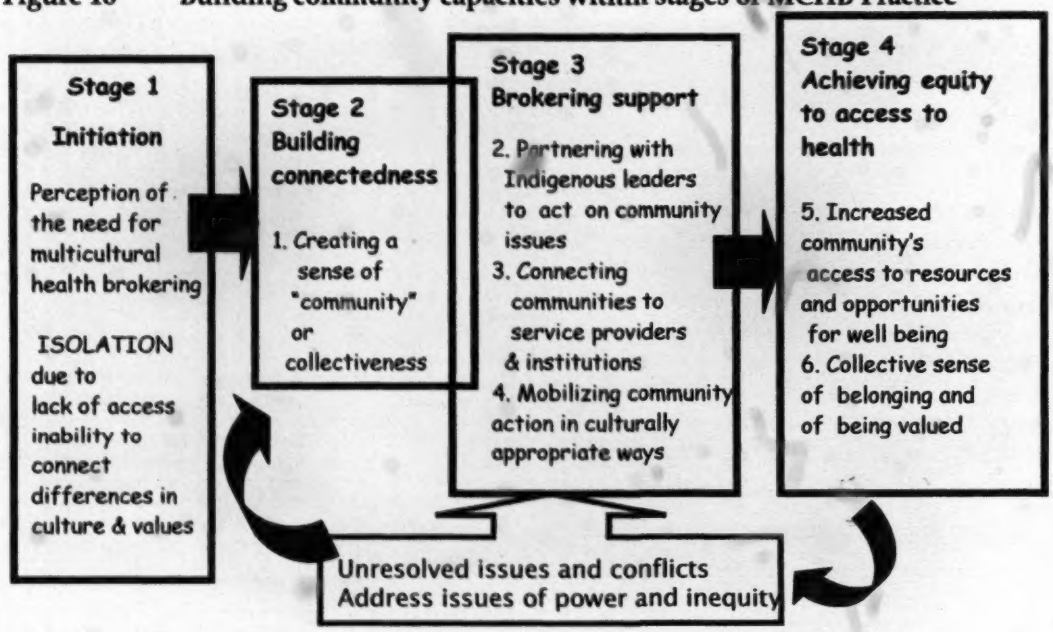
This leads to the second concept, which is self-determination. Self-determination is a reflexive concept that directs the determination towards the self. The self, being a person or persons and, determination, is the "act of making a decision" (Collins Dictionary, p.246). Thus, self-determination is the act of making decision by those who are directly affected by that decision. The two concepts of ethnic minority community and self-determination are profoundly relevant in the multicultural health brokering practice as they relate to the dimension of building a community's capacity for self-determination. This dimension recognizes that ethnic minority communities

have limited or have no access to structures and processes of societal decision-making because of their lower social status and their lack of/or limited capacity to participate in the decision-making process. Building a community's capacity for self–determination involves the process of bringing community members into the dynamic act of sharing and being together to define their own "community-ness", engaging them in the process of articulating issues and exploring their own strengths to address those issues, supporting them to work for their own goals and aspirations; and lastly to become their own agents for change and transformation.

> The need of brokers, the need of some degree of, I would call it social activism, seeking change, will have to exist. The work will always be there. Even if this group of people were, or colleagues, cease to exist, it's going to take a while to change. You see it within communities even, the issues of lack of equity. Until we have created a culture where we're all paying attention to understand why it exists and all, we will always be there, …to try and support communities to create moments of joy for the family, because most of the time they feel like they're overlooked or not valued. And so, helping community leaders even to create moments of a sense of camaraderie, a sense of not being alone, a sense of valued, so that people can continue to stay in the struggle for the rest of the week. (Participant)

The dimension category of building a community's capacity for self-determination has six properties.

Figure 10 Building community capacities within stages of MCHB Practice


Stage 1
Initiation
Perception of the need for multicultural health brokering
ISOLATION due to lack of access inability to connect differences in culture & values
Stage 2
Building connectedness
1. Creating a sense of "community" or collectiveness
Stage 3
Brokering support
2. Partnering with Indigenous leaders to act on community issues
3. Connecting communities to service providers & institutions
4. Mobilizing community action in culturally appropriate ways
Stage 4
Achieving equity to access to health
5. Increased community's access to resources and opportunities for well being
6. Collective sense of belonging and of being valued
Unresolved issues and conflicts
Address issues of power and inequity

Dimension category 4: Catalyzing institutional change for cultural competence

Catalyzing institutional changes is the fourth dimension of the multicultural health brokering practice. It is rooted in the fundamental differences between institutions and community that often creates tension and conflict.

> ... two sets of cultures, or two ways of looking at things, or two realities, and being able to reveal it to each other. But in this case, the two sides aren't really equal. One side has more power than the other. And so in the mediation is more than bring equal understanding. It's almost, there is an element of advocacy or encouraging the side with more power to let go and recognize they need to accommodate, they need to respond to the other side that has less power. In this case, whether it's working with the community, with the system, or family with a social worker, it's very much about being in that in-between space, bringing people together, mediating, negotiating, but always the stronger emphasis is on the side of the community or the family that they are the ones that are disadvantaged. Their perspectives need to be raised more so than the system's. (Participant)

Institutions can be described as large structures with sophisticated systems. They are organized to control and regulate the flow of goods and services as well as to manage a large number of people. Communities are the social places in which people interact and congregate or what McKnight (19871) calls the "unmanaged environment", the great "out-thereness beyond the fringes of professional offices" (p.1). Institutions and communities differ not only about where they are but also in how they are structured. Institutions, by the nature of their structures, are designed to control people through systems and rules to ensure consistency and efficiency of operations. As such, institutions tend to be hierarchical, assigning to their leadership the task of management and enforcement of rules. On the other hand, communities are largely unstructured and activities depend upon the active consent of people. Communities are diverse and dynamic, which allows leaders to emerge and grow. Institutions are commonly regarded as having power through the resources and influence that it yields on citizens and society. Communities because of their diversity and uneven development have to earn and work hard to obtain power.

Institutions are designed to avoid mistakes and failures while communities are vulnerable to mistakes and uncertainties. Institutions, because of their size, are often inflexible and slow to respond to changes. Communities, most often must face unexpected tragedies; surprise developments that are sometimes caused by multiple

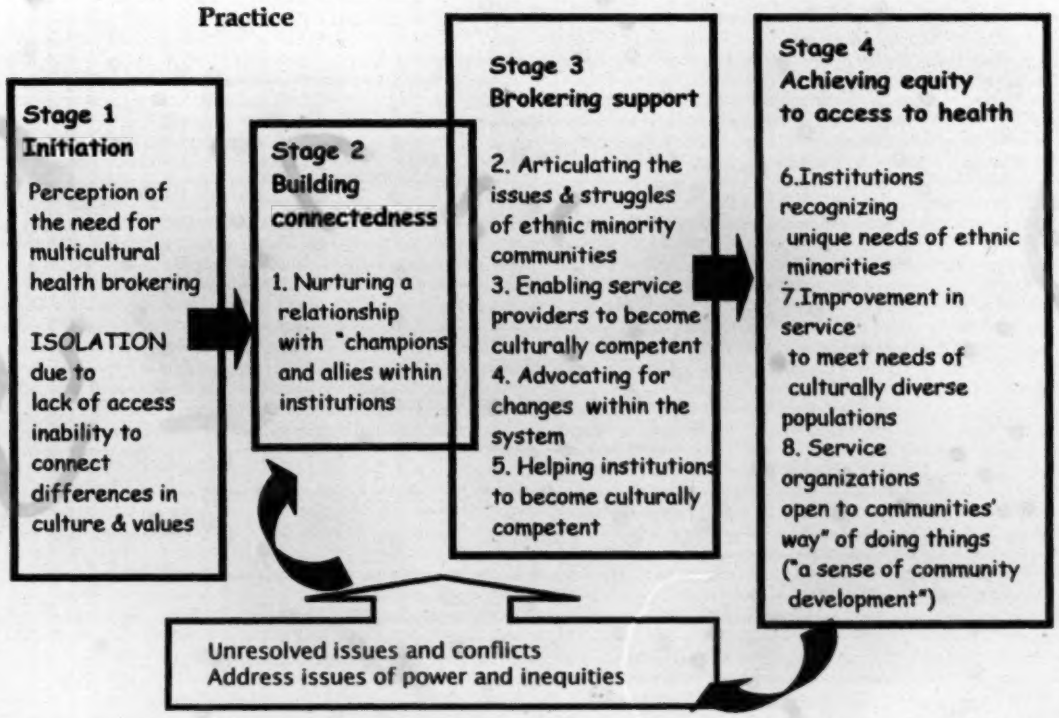
and overlapping circumstances and thus the need to quickly respond is imminent. The system in institutions is a maze of organizational layers and protocols that one must negotiate with the great possibility of getting lost. In communities, there is a network of relationships that are small enough that it could provide the immediacy of support. While institutions foster conformity, communities thrive on diversity. The drive for conformity oftentimes ignores differences while the acceptance of diversity values differences. These differences, however, do not mean that society must choose one over the other because it needs both of them in order to flourish. Society needs them to work together for the betterment of its citizens.

Catalyzing institutional change emerged in the research as a strategic dimension of multicultural health brokering. This dimension seeks to confront the basic tension arising from the differences between institutions and communities and to find a place where these tensions can be resolved. To catalyze is to influence through the action of a catalyst. A catalyst is an agent that speeds up the process of change. The multicultural health brokering practice operates at the juncture of communities and institutions where the vantage point allows greater clarity in understanding two sets of differing realities. Catalyzing institutional change can occur within and outside institutions. Within institutions, catalyzing change involves immersing in the institution's culture to identify and determine where one can make the most significant change. Outside of institutions means finding where the sphere of influence resides and cultivating meaningful and productive connections. Change can occur if both communities and institutions know about each other and can find the best possible combination to work with each other.

> It's very much about revealing a set of realities that's not known and, by not knowing that reality, inequities exist because of that not knowing. And so, in so many ways, it's the function of making it be known to each side, but particularly for the system to know about the struggles of the ethnic minority families, but further to that is to mediate and bring about change no matter how long it might take. (Participant)

Catalyzing institutional change has eight properties within the four stages of multicultural health brokering as shown in Figure 11.

Figure 11 **Catalyzing Institutional Change within the Stages of the MCHB Practice**


Stage 1
Initiation
Perception of the need for multicultural health brokering
ISOLATION due to lack of access inability to connect differences in culture & values
Stage 2
Building connectedness
1. Nurturing a relationship with "champions and allies within institutions
Stage 3
Brokering support
2. Articulating the issues & struggles of ethnic minority communities
3. Enabling service providers to become culturally competent
4. Advocating for changes within the system
5. Helping institutions to become culturally competent
Stage 4
Achieving equity to access to health
6.Institutions recognizing unique needs of ethnic minorities
7.Improvement in service to meet needs of culturally diverse populations
8. Service organizations open to communities' way" of doing things ("a sense of community development")
Unresolved issues and conflicts
Address issues of power and inequities

IV. Discussion: constructing the stages and dimensions of the multicultural health brokering practice

This section presents a detailed discussion of the properties of the stages and dimensions of the multicultural brokering practice. A coding process table is presented for each stage and dimension of the multicultural health brokering practice. Each contains excerpts from the interviews where the open codes were taken, the resulting property and the relevant categories. The Coding Process Table found at the end of the discussion of each stage and dimension will show how the data became codes and how the codes were transformed into properties and categories.

In examining the properties, both stages and dimensions shared similarities. For example, Initiation (Stage One) is a common category for both stages and dimensions and shared the property of isolation. Likewise, empathetic and reflective listening is a property of Stage Two (Building Connectedness) and the dimension of "Providing one-

on-one support". The detailed coding process table will show the same attributes for each stage in each dimension.

It will be noted that a discussion of the properties within each of the categories may not always make references to specific data in the research to support the statements. The assumption in grounded theory is that the resulting conceptual statements are a set of hypotheses constituting the theory. "The assumption of the reader, he should be advised, is that all concepts are grounded and that this massive grounding effort could not be shown in writing...*also that as grounded they are not proven: they are only suggested*" (Glaser, 1978, p.134). In grounded theory studies, the units of the analysis are the processes involved in the phenomenon being investigated rather than the people involved in the process/processes. "Thus, one should write about cultivating or becoming than the milkmen who are cultivating or the nurses who are becoming..." (Glaser, 1978, p.134). The coding table shown for each category offers a slice of evidence that those conceptual statements were derived from the data even if they seem to appear distant from it.

Stages of multicultural health brokering

Stage 1 Initiation

Initiation is the category where the need for multicultural health brokering is identified. It is triggered by the concept of isolation; a theme consistent throughout the data as experienced by individuals, families, communities and institutions. Isolation reveals the deep and complex set of life circumstances ethnic minorities experience in a new country. Isolation results from the inability to access resources for responding to ill health as well as opportunities for maintaining good health and well-being. Isolation also is a consequence of the inability to make connections with people because of limited communication skills and unfamiliarity with the social terrain of the new environment. Isolation is caused by differences in culture and values that often lead to misunderstanding and conflict. Isolation is a concept that synthesizes the immigrant experience that may be transitory or enduring depending on the supports that are available to the newcomer. It must be noted that the conditions attributed to isolation

are interrelated. There can be no singular factor that causes isolation, but a combination of circumstances that bear on the lives of ethnic minority individuals, families and communities. The coding process of isolation as a property of the category of the initiation stage is presented in Table 6.

Table 6 Coding Process for Stage 1 Initiation

Excerpts from the interviews	Open codes	Clustered open codes	Category
Language is one of the problems. The nurse can't provide certain support to the clients because of the cultural issue and the language; really the nurse couldn't do very much with those families. … Some of them of the nurse had some good knowledge about those things but because of the language, they really cannot support the family well. So they are referred to us.	Limitations of the nurse in providing support to an immigrant mom because she can not speak her language	Language barriers experienced by both clients and service providers	Isolation resulting from inability to communicate (service providers and clients)
Like diabetes especially when cardiology is involved, there is a big problem for people to follow the treatment plan 'cause its lifestyle is different, food is very different no matter how much ...they (clients) come here (hospital), they do their job, they integrate their food into the planning but still doesn't work as soon as they go home because they don't know how to do it.	Ineffectiveness of treatment plan when it does not consider cultural eating practices	Lack of awareness of service providers about cultural issues in a health situation.	Isolation resulting from lack of access to services to culturally relevant services
In fact, when I visit one mom, the nurse told the mother not to do that, and it kind of upset the mother-in-law, this is our culture, what are you talking about? But after the nurse left, the mother kept doing it anyway. She doesn't understand why.	Nurse was not aware of role of extended family in making health decisions	Lack of awareness of service providers about cultural issues in a health situation	Isolation of service providers from culturally diverse client
I feel and I know that a lot of these new mothers are usually new from India, they are not familiar with the way the health care system works in Canada, or let's say in Edmonton, and they're unaware of the services which they more than likely can access; they have no idea that they can access those services.	New mothers who are newcomers do not know what resources are available for them and how to access these resources for their health.	Lack of awareness of service providers about cultural issues in a health situation	Isolation from supportive services to address adaptational difficulties, poverty and unfamiliarity with new environment

Table 6 Continued

Excerpts from the interviews	Open codes	Clustered open codes	Category
I think the most one from post-natal moms is isolation and poverty, …because you could see from in their one bed apartment with three kids, .. you know they have poverty issues, but not that, it's really isolation issues....they have a hard time to get out of the house, and then to get involved with other recreational places like swimming, and those kinds of things...back home, they have an easy access to go but here, they have to know where to go, and how much they charge, all kinds of things. Those kinds of things limit them.	Moms are poor and lonely & not connected with their community	Inability to access supportive services and resources especially for newcomers	Isolation from supportive services to address adaptational difficulties, poverty and unfamiliarity with new environment
One of the ladies I saw … she is working in the mall and I saw her baby. I know that the baby was very sick so I approach the woman even if I don't know her and I told her that the baby is very sick. The woman said, "yes, she was vomiting all the time and I took her to the doctor yesterday and she told me that it was alright. Then I told her the baby looks very sick, you need to take her to the doctor now. I did check the baby; she is dehydrated, from her eyes to her hands. I took her to the doctor directly. I told her (doctor) that the baby is dehydrated and the doctor said yes, you need to take her to the hospital. So I took the baby with the mom to the Royal Alex and we put her there.	The mother was not very sure what to do with her baby	Limited knowledge to recognize health issues Lack of self-confidence to seek help. Feelings of powerless-ness	Isolation (resulting from lack of health knowledge in the new culture) Isolation (resulting from inability to seek help)
He was not doing much as he was supposed to do at the daycare center, others that they would call to just to observe this child, notice that he was not acting normal, that it was something, so I was called to talk to the family because this family did not speak English. They were in absolute denial, they thought that there was nothing wrong with the child, they were scared that they were going to take away the child, because the social worker that have come at that time was not able to communicate with them, so it was to help them to understand why he was not coming to take the child per se, ... just to release from that fear...that they were not going to take the child away, but just to see if there was a problem to help the child and that they'll be there to do something about it, and not just ...if there was something to be done, better now than later.	The parent s of the child are not aware or refuse to recognize that there is problem because they fear that their child might be taken away by child welfare	Limited of knowledge of social services	Isolation (resulting from lack of understanding of social services system and how it works)

Table 6 Continued

Excerpts from the interviews	Open codes	Clustered open codes	Category
A man had called me because he had heard on the radio, the things that we were doing, and …we talked for hours on the phone, and he was very worried because his marriage had broken up and he had a problem with his ex-wife, and it was a custody battle, and he loved this child and he didn't want to lose her, but he said every time that he wanted to do something, the courts and the social workers always sided with wife. He just needed a shoulder (to cry on), he needed somebody to explain, to look for options as what else he could do not to lose contact with his child.	The man needed emotional support and felt comfortable talking to someone who comes from the same culture	Need for emotional support for complicated issues. In most occasions, people who have linguistic and cultural barriers cannot readily access the formal social support system	Isolation (resulting from lack of culturally responsive and accessible social support system)

Language barrier is the most easily recognizable form of isolation, especially when it impairs one's inability to communicate in English. In the case of newcomer ethnic minorities, it is difficult to relate with the larger majority of the English-speaking population. This immobilizes people in performing day-to-day tasks such as going to the grocery, shopping, banking, taking the bus etc. People's survival is challenged or jeopardized if employment opportunities are diminished because of limited communication skills. Isolation can be distressing when one cannot articulate health needs and health concerns to a service provider, and when one feels excluded from important health information. Multicultural health brokers often get referrals from public health nurses or other service providers when language is an issue in the provision of service, especially when the main concern is to ensure compliance to treatment. When ethnic minorities are isolated from the health system, it reduces their ability to appreciate other views of health, in this case, the western way of healing. For example, they are expected to make decisions about their health based on the knowledge system of another culture without the benefit of understanding a new knowledge system. It erodes people's confidence and hinders their ability to seek help.

Isolation can also result from lack of awareness and understanding of cultural issues, an associated problematic situation involving ethnic minorities. This lack of

understanding prevents service providers from exploring alternative ways of delivering culturally-responsive and appropriate interventions. When health providers insist on their own ways of responding to a health problem, it alienates ethnic minority individuals from the health system most especially when they are told to do something they do not understand. Mainstream institutions such as the health care system also isolate themselves from the community they serve when they become inaccessible to the people who need them.

Isolation is also a consequence of the adaptational difficulties of being a newcomer and a minority. Many women who sought multicultural health brokers were lonely and had no social connection with other women, even in their own community. Being newcomers, they did not have the facility of language to ask for information about services, to move around freely without fear and anxiety and to seek out friends. Poverty further aggravates feelings of loneliness when someone cannot afford to access recreation. Multicultural health brokers speak of women who are experiencing post-partum depression because of a lack of connection in addition to the overwhelming responsibility of parenting in a totally different context.

> In India, what usually happens whenever a young woman's delivery date comes near, she goes to her mom's for a month, maybe six weeks in advance and stays there until the baby is delivered. She's looked after, practically pampered by her mom, her sisters, practically by the rest of the family, and she's also looked after and pampered, she and the baby, practically two months after the baby is born and then she goes back when she's fully recovered, the baby is bathed by the grandma or the aunt, she is given a rest for forty days, that's for sure, and this is not available here to most moms in Edmonton. Especially with the first baby this leads to a lot of grief. I myself would have gone through the same thing, I had both my children in Edmonton, my parents were not here, or any of my sisters or brothers or so, so I have gone through a lot of things, and like the same thing even though I considered myself an educated woman, it's amazing that I didn't know about a lot of services that were offered, I did not know anything about post-partum depression, which I went through, I didn't have a clue, and I'm sure, I don't think I could even tell the health authorities as to what I was going through, and otherwise it would have been identified and something could have been done about it, but that's how it was, and so I really identified with these young moms who are going through this and I feel that I could offer them a lot of support. (Participant)

In many cases, ethnic minority women are caught in the middle of changing gender roles and seem powerless to deal with the situation.

> Also the lack of knowledge about (Canadian or western) cultural issues, they've lived with their culture for so long, and then they come here, it's too hard for them to adapt to the new culture, where the husband comes home and sits there and waits for a meal, they

> probably don't have the idea of sharing ... why the husband have to help the wife somehow, they don't have that frame of mind, all the time husband comes home, just sits there and watches TV and then be on the table, so that it makes it harder for the wife, because the wife also works, and not at home. (Participant)

Isolation happens when people are not aware that there are resources available to address their concerns. Information about social services hardly reaches ethnic minority communities and even if it does, this information is written in English. Sometimes information can come from informal sources which are inaccurate. Thus, misconceptions in ethnic minority communities arise, particularly in sensitive areas such as child welfare or family violence. Even when people know about certain services, they are still inaccessible and unappreciated by ethnic minority communities because they have no cultural experience about these services. For example, in an emotional crisis, people are more likely to talk initially to someone in their own language and who is culturally familiar to them. They might not phone an assessment line or wait to be referred to a counselor, expecting that the conversation will most likely be conducted in English.

Ethnic minorities as a community are also isolated from the larger society, particularly those who are from unorganized, fairly newer and smaller communities such as refugee communities. People from these communities most likely came to Canada involuntarily and would have health issues as a consequence of difficult immigration experiences i.e. post-traumatic stress. They would most likely have greater needs than others. Being a minority group is defined not only in their small numbers relative to the majority but also in terms of their relative power and influence in societal decision-making. This situation marginalizes them from vital social, economic and political opportunities and most often this isolation further makes them invisible and unattended.

> Whether it's about teen or about very lonely seniors, immigrant seniors, or about women who are the most marginalized immigrant community, it speaks about power, it speaks about lack of power, it speaks about some in this society still are more valued than others and, and it speaks about people not feeling, basically, valued, that they are not living their lives to the fullest with the greatest amount of dignity, you know, based on their own talents and strengths, those talents and strengths are overlooked, they're looked upon for other, or measured up in accordance to certain other dimensions, colour of their skin or having born somewhere else, or speak another language, you know. And so the themes are so resoundingly common across the communities that in the end, that there's

maybe only one issue, is that, we still haven't found a way to create true justice in a diverse society…(Participant)

Recently, emerging literature on social exclusion has increased the conceptual relevance of isolation by explaining the experiences of ethnic minorities. To be isolated is also to become socially excluded. In the community development literature, social exclusion is seen as a "process whereby individuals and groups and the environment in which they live are excluded from the resources and opportunities, which are, considered the norm in a society. It is not just about scarcity of material resources but lack of opportunities, isolation, discrimination, marginalization from decision-making and from an adequate quality of life"(Population and Public Health Branch, 2001, p.1). The effects of social exclusion are enduring, as Prime Minister Tony Blair of the United Kingdom explains: "Social exclusion is about income but it is more. It is about prospects and networks and life chances. It is a very modern problem and one that is harmful to the individual, more damaging to self-esteem, more corrosive to society as a whole, and more likely to be passed down from generation to generation" (Guilford, 2000p. 3). The World Health Organization Regional Office in Europe included social exclusion as one of the social determinants of health. In its policy paper, the WHO has identified ethnic minority groups, particularly refugees who are vulnerable to social exclusion and children who are more likely to be at special risk of poor health (Wilkinson & Marmot, 1998). Diminished opportunities for work and education, racism, discrimination and hostility are risks minority groups often face that are harmful to their health.

Social exclusion is also expressed in people's participation in societal activities and decision-making. Studies as well as anecdotal evidence indicate low participation rates of visible minorities in community development activities, social services programs and political processes (Galabuzi, 2001).

Exclusionary social process such as isolation and poverty diminish the ability and confidence of ethnic minorities to articulate their concerns and aspirations and further leads to loss of control over their life circumstances. Multicultural health brokering offers a bridge by which ethnic minority individuals, families and communities can increase their life chances and opportunities.

Stage 2 Building connectedness

Building connectedness has six properties across the four dimensions. These are the following:

Dimension 1: Providing one-on-one support

- Empathetic and reflective listening
- Creating trusting relationships

Dimension 2: Building supportive groups

- Finding common interests and needs
- Creating a sense of togetherness

Dimension 3: Building the community's capacity for self-determination:

- Creating a sense of "community" or collectiveness

Dimension 4: Catalyzing institutional change:

- Nurturing "champions" and allies within institutions

Dimension 1: Providing One-on-One Support

Listening in the multicultural health brokering practice is described as empathetic listening – the ability to sense and understand people's feelings as if they were their own. Empathy comes from the shared culture and experiences inherent in the listening process. There are countless examples of shared experiences between the multicultural health brokers and their clients mentioned in the interviews such as being a newcomer, an immigrant, fleeing one's country as a refugee, being a mother, or being lonely and isolated. The multicultural health brokers speak with an affirming smile or reassuring nod that sparks instant rapport with their clients. This rapport eases the people's discomfort about disclosing deeper concerns. Authenticating the other person's experience is very important in achieving empathetic listening.

Reflective listening involves acknowledging the other person's knowledge of how they understand their situation ("mirroring"), clarifying what the other person is saying by providing affirming feedback and offering generative questions. What is brought into the initial encounter is cultural knowledge as well as experiential

knowledge that helps frame questions to generate a context for the person's life situation. In an evaluative report of the work of multicultural health brokers in the Perinatal Health Project in 1997, one of the minority parents interviewed said this:

> We trust (MCHB). She attends to feelings and shares her experiences of being a mother. She spent time with us and supported our hopes. Seeing her with healthy children makes me more comfortable. Maybe doctors have children but I do not see or hear about them. She cares for us and not the system. (Wolfe-Gordon Consulting, 1998,p.32)

The act of empathetic and reflective listening supports what Freire calls "generative inquiry" (Pilisuk, McAllister, & Rothman, 1998). This begins with active listening, posing questions that generate people's hopes, aspirations, fears, problems, vision and dreams. This opens up the dialogue to where people become engage in a deeper reflection of their situation and aim for seeking solutions and changes. In multicultural health brokering, listening keeps the practice grounded in people's realities and guides the exploration of strategies for support.

Creating a trusting relationship comes from empathetic and reflective listening. A trusting relationship is the human expression of being connected to someone. In multicultural health brokering, creating a trusting relationship with people is an ongoing process. It starts with "being there". "Being there" evokes warmth and instant rapport when two people speak the same language, look like each other, have the same cultural knowledge and experience or can identify with a familiar figure such as an aunt, a sister, friend, mother etc. Familiar figures are important in multicultural health brokering because of the significant influence of family members in many cultures. Multicultural health brokers are often addressed using a reverential term in their own language that means an aunt or an older sister. For example, among Filipinos a sign of respect for an older woman is to call her "*ate*" which means elder sister, even though she is not related to the other person. Multicultural health brokers are endearingly addressed by their clients as "aunt" or "older sister", reflecting cultural traditions of familialism or an orientation towards the familiar and the natural.

Creating a trusting relationship also means reassuring the other person that he/she can express his/her thoughts and feelings in the presence of someone who will

not make a "professional judgment" of their situation. In multicultural health brokering practice this is called "normalizing the situation", as coined by one multicultural health broker.

> I think my role in the client's eyes would be one of like a 'she really cares', 'she's one of us' and 'she knows what she's doing" and that would be it and my role is just to be in the middle and not only doing what is appropriate and just being there for them and making them feel that you know that you care for them. It's just making the situation normal or natural or making it (less painful – I), yes than having to sit down and talk to a social worker or a doctor. (Participant)

"Normalizing the situation" is manifested when multicultural health brokers visit clients in their homes, when they talk in a less-formal language without using technical jargon and when they exude warmth and compassion to make their clients feel at ease and safe.

Creating trusting relationships also involves meeting some of the practical day-to-day needs of the clients as they work through the process of seeking solutions to their problems. Examples are making the initial phone calls for appointments and showing clients how to do it, arranging child care for moms when they go for doctor's appointment, driving clients to clinics during the first visit or helping them move to another house. For people who have no social networks to turn to or have limited resources, these practical supports become very important for them and help them focus on the issues or concerns at hand.

Creating enduring personal relationships with people is what makes multicultural health brokering a unique practice different from the practice of professional and institutional-based caregivers. The multicultural health brokering practice rejects what is known as "professional distance". This happens when human services professionals place boundaries in roles and relationships between clients and those providing service. In common language, professionals should not get personally involved with a client as it might affect certain professional and technical judgments. John McKnight (1977) believes that "professional distance" is the result of what he calls "unilateral service" in the professional business. The assumption behind unilateral service is that the client is the problem and the professionalized caregiver is the solution. "To be professional is to distance, to insure that the relationship is defined in terms that allow the client to understand who is really being serviced" (McKnight, 1977, p.114).

Whether it is a stated or hidden assumption, the unilateral nature of professional relationships in McKnight's view undermines a democratic and participative process where the goal is to build people's capacities to solve their problems. This unilateral relationship is in fact a disabling function because embedded in the professional relationship is the assumption of power and dominance over the clients. Clients tend to depend on unilateral experts and professionalized helpers. In multicultural health brokering, there is a tacit assumption that the primary purpose of helping people starts from being a member of the same cultural and ethnic community and one that fosters social responsibility and caring for others. As such, creating and maintaining trusting personal relationships with clients is inherent and central to the supportive and nurturing functions of the practice. Multicultural health brokers come into context as someone who is not different from them, almost as equals or comrade-in-arms, or better yet as partners who will journey together in search for solutions to problems or realization of hopes and aspirations. As one participant said:

> I usually see my relationship with clients as an alliance. (Participant)

Multicultural health brokers are integral to the community life of their clients – they meet them at grocery stores, in churches, temples or mosques and at community events. They also get invited to family events. The multicultural health brokers share human needs just like their clients and fulfill an "emptiness" (McKnight, 1989) that most human services professionals often overlook or ignore. It fulfills the need for people to express themselves as persons with strengths, capacities and gifts, not only as people with needs and issues. Creating trusting relationships moves people from a state of isolation to a place of connectedness where they can find affirmation and support. Ultimately, the trusting relationship created within the multicultural health brokering addresses the power imbalance in the helping relationship by achieving true reciprocity (Jacobson, 2001).

Table 7 Coding Process for Stage 2 "Building Connectedness" Dimension: Providing One-on-One support

Excerpts from interviews	Clustered open codes	Properties
It will never be like you know you ask me a question then I answer. They will talk and you will find out. I'll ask them questions during the conversation *He just needed a shoulder, he needed somebody to explain, to look for options as what else he could do not to lose the contact with his child.*	Listening with depth Taking time to understand issues Relieving client of their load and issues	Empathetic listening
... because I personally have experienced this, these difficulties, I don't want anybody else to have to go through that. And so, I will use what I remember in terms of the experience and even the feelings, so that I work in a very authentic way.	Putting yourself in the situation Authenticating client's experience	Empathetic listening
To help them listen to their problems and clarify their problems and look at their problem at their way, so they can talk to me about their problem and also interest them and help them to analyze their problem, and they can solve it on their own. *Well, I think at first I need to understand where they come from-I need to understand their position, their fears, their worries, what is more...the most important at that moment in time, with the knowledge that there might be something else underlying there at the beginning.*	Mirroring and clarifying what the client is saying Establishing the client's context	Reflective listening
Many times, they know me, they look me, if it's a younger woman, as a mother figure or an aunt or something like that, so it is... *My clients come to me because I am from their own community. It is easy for them to communicate with someone from their own culture and who knows their own language. We have been through the same thing-the same struggle. Most of my clients are also mothers. I am a refugee, immigrant, woman and mother so I can identify with many of my clients.* *For friendship, to help her with day-to-day situations.*	Being there as a familiar figure Instant rapport with people who have the same cultural backgrounds Providing a safe place to talk and share Providing practical support	Creating a relationship that comes from having similar cultural backgrounds

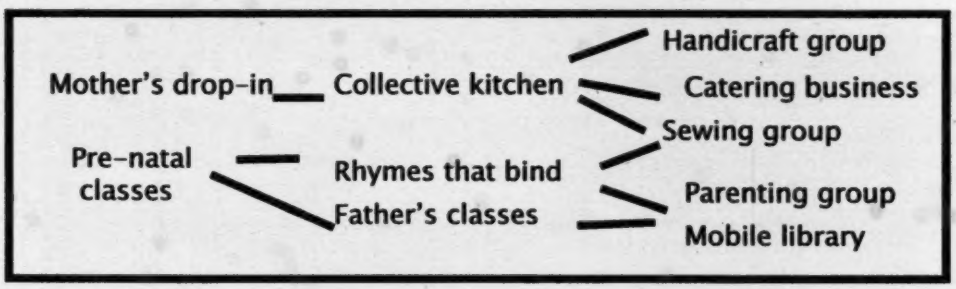
Dimension 2: Building supportive groups

Finding common interests and needs is a property that describes how supportive groups are built among individuals who seek connections with others. This connection could start around the need for new knowledge relevant to people's lives, such as parenting or health information or the need to connect with others in the community. Building supportive groups is about creating opportunities for people to improve their

knowledge and behaviour through group connection. Supportive groups start out as pre-defined health education programs such as pre-natal classes, collective kitchens etc. They facilitate social connections within the community while meeting practical needs. Once these health education groups become active, they seem to take on a life of their own. When building supportive groups, the participants talked about how groups developed after starting out as pre-natal classes and then evolving into different types of group depending on what the group identified to be a need or interest. For example, in the Chinese community, what started as a pre-natal class is now a flourishing parent's drop-in where mothers meet to attend health education classes and participate in collective kitchens and sewing classes. The Vietnamese community has a group of former pre-natal class participants who are now offering catering services.

Figure 12 shows examples of health education activities that evolved into small groups for support and community development as experienced by MCHBs undertaking group development work:

Figure 12 Small Group Development in the MCHB practice



Creating a sense of togetherness is another property of building supportive groups that ethnic minority women experience in the multicultural health brokering practice. This property addresses the issue of social isolation of many newcomers, particularly first-time mothers who speak little English and are not familiar with Western ways of childbirth and parenting and have difficulty seeking connections. The multicultural health brokers bring these women together to build enduring connections and open opportunities to discover their talents and skills. The sense of togetherness

that the ethnic minorities felt in many of these groups have helped sustain these supportive groups in the community. Hurdle's (2001) research on social support among immigrant women revealed social connections as a critical factor in women's health.

Table 8 shows the coding process for building connectedness and building supportive groups.

Table 8 Coding Process for Stage 2 "Building Connectedness" Dimension 2: Building Supportive Groups

Excerpts from interviews	Properties	Dimension
... when I see my clients and talk to them, I tell them what I do and when it's time to get a group I get one mom to help me coordinate the group, make phone calls, to organize the place and all that, and they get empowered too, they feel that they are doing something for themselves... so they take turns, ...these women don't go out of the house. It's too much for them to take the child out, much more take the child in the bus but that's something in our culture, you just don't do that... once women come out and they enjoy so much, these the ones who keep coming back. Surely, you add other women but the original ones go for a long time and those are the ones that bring other women too.	Finding common needs and interests	Building supportive groups in ethnic minority communities
Because we want to drop in every week, actually we encourage the moms to come, it's because it's good for them, so it eliminates isolation, so they can gain social support from other moms, and then they also come out and we can do one-on-one counselling and support for the pregnancy.	Creating a sense of togetherness	

Dimension 3: Building a community's capacity for self-determination

Creating a sense of "community" or collectiveness is a property of the dimension of building a community's capacity for self-determination and is also a category of Stage 2; building connectedness. The important first step in building a community's capacity for self-determination is creating and nurturing a sense of "community" and "collectiveness" in any community that is struggling with many issues associated with isolation and adaptation.

> ... we will always be there, to try and support communities to create moments of joy for the family, because most of the time they feel like they're overlooked or not valued. And so, you know, helping community leaders even to create moments of, sense of camaraderie, a sense of not being alone, a sense of valued, um, so that people can continue to stay in the struggle for the rest of the week... (Participant)

Communities where the MCHBs work are diverse and dynamic. Diversity is to be found not only in the origins of the community members and their culture, language

and ethnicity but also in the level of community organization. In my own observation working with different immigrant communities in Edmonton, older communities, which have a longer immigration history, are fairly large and well-established. They have organized social support networks that can address a variety of community needs such as physical access to services, community organizations and a pool of indigenous health and social service professionals. Yet, even in these communities there are large pockets of the population who are isolated and struggling with very difficult life circumstances, and the existing community support system cannot cope with the complexity of their problems. Participants in this study mentioned that they had been asked by community leaders to help them explore emerging problems associated with older immigrant communities.

> It's the same with the community leaders who might come to us and say we're trying to work as a community to resolve issues around preventing our youth in entering into crime or joining gangs. Again, it's about piecing, seeking out really, um, powerful intervention that other people have used, and trying to see if even this intervention will fit this cultural context, right. So, like, say, one of the southeast Asian communities is really concerned about their youth in crime, uh, and yet the community really, so far, the parents don't want to talk about it. They just, every day they're fearful for their children, but they find it shameful to talk about it, and so you can't bring the community together. (Participant)

On the other hand, there are several communities that have smaller populations, largely unorganized, and have life situations that put people at greater risk of illness. These communities are composed mostly of refugees who escaped to Canada in the last ten years as a result of civil war in their home country. Multicultural health brokering practice in building a community's capacity is just as important in smaller and emerging refugee communities. The multicultural health brokers work closely with smaller and emerging refugee communities such as the Somali, Sudanese and Cambodians, to name a few. These communities need intensive support because they are isolated and marginalized. The interaction of multiple factors and circumstances such as the pre-migration experience coming from countries at war or in political turmoil, inability/difficulty to communicate in English, cultural differences in health and social values and limited access to social support, all increase the vulnerability of these cultural groups to illness and disease. People in these communities have lived in refugee camps

for many years before their arrival in Canada. These refugee communities have often asked the multicultural health brokers to help them access support to address important concerns in their community. For example, child health issues are common themes across communities. This theme concerns mislabelling children in school with behavioural or learning problems when the main reason was that the child cannot speak English fluently. Among the issues that the multicultural health brokers have dealt with are children who were born in refugee camps who had not attended any formal schooling and who are placed in grade levels based on age without anyone considering the child's pre-migration circumstances. Parents are struggling to understand why this is happening; the school is unaware of some of the specific circumstances that children of refugees had experienced.

Table 9 Coding Process for Stage 2 "Building Connectedness" Dimension 3: Building a Community's Capacity

Excerpts from interviews	Properties	Dimension
We will always be there, to, try and support communities to create moments of joy for the family, because most of the time they feel like they're overlooked or not valued. *And so, helping community leaders even to create moments of, sense of camaraderie, a sense of not being alone, a sense of value, so that people can continue to stay in the struggle for the rest of the week.*	Creating a sense of togetherness and of being valued	Building an ethnic minority community's capacity for self-determination

Dimension 4: Catalyzing institutional change

Finding and nurturing "champions" and allies within the institution is a property of the dimension of catalyzing institutional change and the stage of building connectedness in the MCHB practice. This property involves identifying and connecting with an insider within the institution who is enlightened and committed enough to take up the task of initiating and facilitating changes in the institution. Nurturing insiders in the change process entails supporting workers within institutions to articulate the needs and concerns of ethnic minorities by providing them with timely information and keeping them grounded on the realities of people's life circumstances. The multicultural health brokering practice creates cultural encounters for mainstream workers; they interact with the people from culturally diverse communities. The purpose of these

encounters is to increase the level of awareness and understanding in mainstream workers about ethnic minorities whom they are advocating for in the system.

Over the years, the multicultural health brokers as individuals and the MCHB Co-op as an organization have been able to build enduring connections within the health system - and recently in the social services sector - that enabled institutions to provide more resources for ethnic minorities (Multicultural Health Brokers Cooperative, 2001). Through the influence of the Co-op's champions and allies, there have been incremental changes indicative around certain institutions' willingness to try new ways of responding to diversity. For example, there is an openness to providing multicultural health brokering services in the area of primary health care, mental health, child welfare and early childhood development (Multicultural Health Brokers Cooperative, 2001).

Table 10 shows the coding process for this property.

Table 10 Coding Process for Stage 2 "Building Connectedness" Dimension 4: Catalyzing Institutional Change

Excerpts from interviews	Properties	Dimension
Our Volunteer Coordinator here, when I started here, in meetings she was listening to me but the door was shut, after that a few times she passed me in the hallway and she would not acknowledge me as if she didn't know me. This year, she came to me and she said we should talk… I just felt that the way she talked to me and all that and my program and I have to do this, I just have to let her know that it's important. I know I need to get the influence and the support of my manager to make change and I felt sort of an outsider but it's changing now. I gave her a couple of mental health things. She went to the convention by the Pediatric nurses with children and culture. She came back and she was quite pumped up about things and you know, things are working out very well.	Nurturing a relationship with "champions" and allies within institutions	Catalyzing institutional change towards cultural competence

Stage 3: Brokering support

Brokering support for ethnic minority individuals, families and communities means facilitating access to resources and opportunities that meet the needs of those who are unable to obtain them on their own. This inability is attributed to personal, social, cultural, economic and political barriers. The aim of brokering support is to be able to mobilize resources for ethnic minorities by helping them articulate their needs,

exploring the best options to meet their needs and connecting them to relevant resources. The category of brokering support has 13 properties shared by the four dimensions of the multicultural health brokering practice:

Dimension 1: Providing one-on-one support

- Generating holistic and critical knowledge
- Bridging/mediating different cultural perspectives
- Connecting to relevant resources
- Advocating for individuals and families

Dimension 2: Building supportive groups

- Creatively responding to progressive needs and concerns
- Leveraging support for group needs

Dimension 3: Building the community's capacity for self-determination

- Partnering with indigenous leaders
- Connecting communities to resources
- Mobilizing community action in culturally appropriate ways

Dimension 4: Catalyzing institutional change

- Articulating the issues & struggles of ethnic minority communities
- Enabling service providers to become culturally competent
- Advocating for changes within the system
- Helping institutions to become culturally competent

Dimension 1: Providing one-on-one support

Generating holistic and critical knowledge about a problematic situation engages the client in conversation about herself/himself and life itself. This process assigns a triadic role for the multicultural health broker: the knowledge seeker who generates the questions, the trustworthy listener who affirms and reassures and the truthful artist who recreates the images of the client's perceived reality with depth and empathy.

Whether the work involves supporting new moms towards a healthy pregnancy or helping families cope with breakdowns in relationships, cultural knowledge is key in mapping out issues and problems together. The knowledge-seeking process can start with a simple question of "how do you like it here in the new country" that opens up a rich dialogue of hopes and fears. A mental checklist provides a good guide for multicultural health brokers to explore issues about immigration experiences, family relationships, economic circumstances and social networks. These are conversation pieces that could turn into a cache of information to plan and organize the supportive arrangements for a particular client. It is through generating the holistic picture of the presenting issues that underlying factors or circumstances are discovered.

> From the conversation not just asking pre-natal questions, but starting from pre-natal questions and we go around, around, around the life and we start to discover there are many problems, issues with their life, marriage, relationships, all kinds of things. (Participant)

Bridging/mediating different cultural perspectives is pivotal in brokering support for individuals and families. Almost always, there are two different cultural perspectives being mediated: one is the indigenous knowledge and cultural experience that individuals and families bring into a health situation and the other is the western biomedical tradition. Often it is usually the health system that has the privilege of naming the conflict situations, such as a patient being "non-compliant" even if the source of conflict could be the system's inability to adapt accordingly. For example, simple nursing instructions are often given to people without consideration of language or their familiarity with the context of the instructions. A multicultural health broker tells a story about an immigrant father who was told to buy shampoo for his child. When he went to the supermarket, he was confused to find out that there were many different kinds of shampoo (i.e. dog shampoo, carpet shampoo etc.). Car seat safety education is another area that many immigrants find difficult to appreciate, as they have a different perception and experience of child safety. For many immigrants from countries with underdeveloped economies and especially refugees who have lived through war, child safety has a different meaning for them. Where bombings and gunfights were daily occurrences and child prostitution was a way to overcome poverty, car seat safety seems to be a trivial concern for them.

> Cultural brokering involves bridging cultural issues. I have clients who have lived in refugee camps for years. One of my clients described the situation when he said the word "health" didn't exist in the camps for him for four years. There were no doctors, the hospital was far away, and services took a long time to get... Many people have bad teeth, children were not immunized on time, and there were no contraceptives for women. There were mental health issues, but there was no attempt to solve these problems in the camps. (Participant)

The mediating function within the multicultural health brokering theory contributes to an understanding of the two cultural perspectives. The pivotal element of the mediating and bridging functions is the ability to see where the point of unity exists when one is at the juncture of two knowledge systems; where the masterful blending can begin. The act of bridging and mediation is to find common ground for understanding and use this common ground to open up communication and bring about harmonious encounters between people from two different cultural perspectives. For example, blending an expectation of what is in the best interest of the client is often the point of unity: here support is negotiated between the client and service provider.

Connecting with relevant resources is the most visible part of brokering support. In this case individuals and families are able to obtain or access resources to meet their needs and goals. The multicultural health brokering practice involves connecting people to resources and thus requires solid grounding of their needs, desires and circumstances, exploring the best possible options, and creatively seeking the right combination of skills and resources. Connecting to relevant resources begins with navigating the system to see what supports are available as well as exploring community opportunities that might be useful. Once these supports are found, negotiating takes place with the specific service provider, agency or institution and community group. Advocating is also involved in this process but a separate discussion will be devoted to this later in this section. Negotiating is necessary to complete the connection. It can occur at various levels with front-line staff, program managers and department heads. From the participants' experience, the best connection is someone who has the most influence in the outcome of the negotiating process. It could be the receptionist who can squeeze in a doctor's appointment, the program assistant who can be flexible to accommodate someone into a program, or the middle manager who knows where resources can be accessed.

Advocating for individuals and families who are marginalized and less powerful is best explained by the following statement:

> ... two sets of cultures, or two ways of looking at things, or two realities, and being able to reveal it to each other. But in this case, the two sides aren't really equal. One side has more power than the other. And so in the mediation is more than bring equal understanding. It's almost, there is an element of advocacy or encouraging the side with more power to let go and recognize they need to accommodate, they need to respond to the other side that has less power. In this case, whether it's working with the community, with the system, or family with a social worker, it's very much about being in that in-between space, bringing people together, mediating, negotiating, but always the stronger emphasis is on the side of the community or the family that they are the ones that are disadvantaged. Their perspectives need to be raised more so than the system's. (Participant)

Advocating within the multicultural health brokering practice recognizes that persistent inequalities exist in Canadian society as documented by Galabuzi (2001). These inequalities adversely influence health and more profoundly affect those who have less power and fewer resources. Advocating in the multicultural health brokering practice is viewed as a strategy of equalizing the situation of people who are at the lower end of the socio-economic scale. Advocating means acting on people's behalf when their capacity to represent themselves is not fully developed. It could also involve increasing people's knowledge about how things work in the new culture so that they can have the tools to ask questions. The multicultural health brokers also call this "levelling the situation" for the disadvantaged and the less powerful.

Table 11 shows the coding process for brokering support (Stage 2) and for providing one-on-one support (Dimension 1).

Table 11 Coding Process for Stage 3 "Brokering Support" Dimension 1: Providing One-on-One Support

Excerpts from interviews	Clustered open codes	Sub-Category
To help them listen to their problems and clarify their problems and look at their problem at their way, so they can talk to me about their problem and also interest them and help them to analyze their problem, and they can solve it on their own.	Talking it out and organizing their thoughts	Generating holistic and critical knowledge about health issues and life circumstances
I like to give the ownership of the problem and the solution to the client, and so my approach is mainly what are the pros and cons, what are their needs, so we usually would sometimes sit down and talk about 'ok, so these are the needs and this is what the real problem is', so sometimes because they don't know what is out there, I would give them options, I would tell them about the different resources that are there, and hope that they	Mapping out issues & problems together Gathering all the facts to see the whole picture	

Table 11 Continued

Excerpts from interviews	Clustered open codes	Sub-Category
themselves can make the decision on their own. First I need to understand where they come from-I need to understand their position, their fears, their worries,... the most important is that there might be something else underlying there at the beginning. This is the issue at hand, let's deal with this issue, and then we go back and explore the rest…	Analyzing critically by revealing multi-layered or underlying issues Focusing in	
I tell them about nutrition, I tell them about the services which are available, I ask them about the feeding practices, I am a great proponent of breast feeding, and the baby's nutrition. …we go through diapers s, and how many wet diapers, the poops and the pees to reassure the mom that there might be another reason that the baby might be crying and it's not really that your breast milk isn't enough for the baby, let's look into that, … and there are tons of reasons, we all know that the baby is crying not just because he is hungry, so that reassures them. I also make sure to touch upon the use of a car seat thoroughly, as to what is OK and what is not OK, and I also ask them if it was a second or a subsequent baby if something like that might have happened to them, in which case, we have to make sure that it does not happen the second time, no I mean she may have post-partum depression or blues, but it does not go unnoticed. *I give them tools to work along, like information in Spanish and English that they can read in both languages so that when a nurse or a doctor would come to them in English, they will know what they are talking about or how to respond.*	Sharing "technical" health information to clients	Bridging/ mediating different cultural perspectives and understandings
I was bringing young lady who was wearing the hijab, she look like Moslem and she is asking for this (tubal ligation). I discuss this with the woman and she said her husband wanted this to be done. The doctor was looking at me. Okay, I understand your confusion. This is against her religion but we respect what she is asking. Most of the time, the doctors and the nurses do ask how we can approach situations according to the culture or religion. Is it acceptable to say that, to give them the results back, how to ask questions. What is the easiest way to tell the client, what she wants, what she doesn't want etc. *The health provider didn't understand why because when she visited the mom, the grandmom doing a massage for the breast, when you have sticky rice and put it in a towel and they massage your breast and they don't understand why. The health provider says that there's no need to do that, that it will create more pain, you know, but they should understand that it doesn't create more pain, that it's the same method as we massage to relax the muscle. When I explained to the health provider, it's one of the nurses, they say 'Oh', it's the same method as we told them to stand in the shower and have the shower just go down on their breast, just to release the*	Explain to clients what to expect from health providers and the health system Discuss with service with health providers about clients' situation and needs Explain cultural practices to health providers	Bridging/ mediating different cultural perspectives and understandings

Table 11 Continued

Excerpts from interviews	Clustered open codes	Sub-Category
engorgement, that's the same method. But to my culture, people think that's not the massage process, but the cooking process, that is, we try to cook the milk to get it cooked. The milk is uncooked if you don't do that. That's how my people think, but what health providers here think is that that is unnecessary. So I explained that that is the massage process.	Mediating between clients' needs and health providers' expectations	Bridging/ mediating different cultural perspectives and understandings
The woman, she felt comfortable to talk about her issue to me, by the time...she goes to the doctor's office or another agency, she doesn't feel comfortable because (of) the language barrier.... I also clarify the question or the need or the request to the other worker, or the doctor, the nurse. *It usually starts with pre-natal care. They sort of are adjusting here, these new circumstances of having a child and the uncertainties that come with that. In addition to them being new here, what to do, where to connect for pre-natal services, how does it work here and then other family matters that come up, relationships with their older children, parenting, how to connect with other immigrant services, employment. Anything that comes up really.*	Rehearsing with clients/prompting client for an encounter with a health provider Exploring options for supporting clients	Connecting with relevant resources
When I started out, I had this expectation that I would be the resource person for them to provide them with the information. What had happened is that I'm doing most of the connecting. It's impossible to know everything. There is so much to know with the health system and all the others. I've been doing mostly say, "Let's call this person and see, let's do this" so I would do this with the family. So this has been the nature of my work, the connecting. *I'm on the issue that they want to, and they learn from one situation to another situation. Although sometimes they come back with their friends, and they say, "Oh, my friend has a problem", some issue then I feel happy that they refer other women (their friend) to me because we feel a network connection among us, among them.*	Finding the best approach to meet a client's needs Referring and accessing clients to the right resources Navigating the health system Linking women to other women in the community	Connecting with relevant resources
My biggest role is advocacy. I advocate on behalf of my clients because there is a great deal of misunderstanding between clients and health providers. *Sometimes the school has a problem with their child, so sometimes, the parents have asked me to intervene on their behalf.* *Culture is a big factor in our work. In Canada the dominant culture is western culture. This is a totally new system and culture to my immigrant clients. Also, the clients learn and understand what rights and responsibilities they have. Our job is to make sure that the process goes smoother and faster.*	Act on behalf of the clients Speak on behalf of the clients Increase people's access to knowledge about heir rights sthey can exercise and protect those rights	Advocating for the less powerful and the marginalized

Dimension 2: Building supportive groups

Creatively responding to progressive needs and interests is a property that describes how a group responds to the changing interests of its members determined primarily by the life stages of children. For example, a pre-natal group can become a parenting class once a baby is born. Parents participate in programs such as Baby Talk (language skills development) and Rhymes that Bind (parental bonding through songs and poems). Most often the parents identify their needs by suggesting topics for discussion in the classes. Parenting classes are popular, particularly for those who have toddlers and younger children. Collective kitchens, more than just cooking classes, provide an interactive action-oriented group activity that builds both personal and group skills such as self-esteem and co-operation. Some collective kitchen groups grew to become catering businesses. The variety of activities in the supportive groups shows the diversity of needs and talents of clients. Multicultural health brokers organize a variety of group activities for parents and children such as sewing classes, recreational dancing or homework clubs.

Leveraging resources is a property that is important in organizing and maintaining supportive groups. This involves a resourceful and creative search for resources that nurtures the talents and skills of the groups. As well, it means tapping into existing programs that have allocated resources. In some cases, it involves accessing external funding by writing proposals. Table 12 shows the coding process for this dimension.

Table 12 Coding Process for Stage 3 "Brokering Support" Dimension 2: Building Supportive Groups

Excerpts from interviews	Properties	Dimension
One group is a pre-natal class, and then the Post-Partum Support group is still there, but it expanded, to programs, like Parenting Together and the women get together and they have a training, Rhymes that Bind…now we have, first Sunday for pre-natal class the next Sunday is sewing and music class, and the last one, we put cooking in there, and the last Sunday of the month, the time is longer, from 1-5, so the women have more time to sing with their children, sometimes they learn how to exercise, dancing, tai chi, so it depends on (them).	Creatively responding to parents' progressive needs and the interests of group participants	Building supportive groups

Table 12 Continues

Excerpts from interviews	Properties	Dimension
In our drop-in, we don't only do Health for Two, but we have Rhymes that Bind program, Mobile Library, Health Talk, and we also have children's program, so there's quite a variety of… services here, so the moms not only come here for pregnancy support, but they also come here for parenting issues, they come here as a social gathering and besides the drop-in, we also run collective kitchen, so some of the moms, they can just stay together and go to the kitchen.	Leveraging support for group needs	Building supportive groups

Dimension 2: Building a community's capacity for self-determination

Partnering with indigenous leaders to act on community issues is a strategy for brokering support within ethnic minority communities. Finding who are the respected indigenous leaders in the community is a starting point for building working relationships with them. It is important to know that smaller ethnic minority communities still keep their cultural traditions of leadership even within a different cultural context. For example, elders, religious leaders and spiritual leaders are respected and held in high esteem and could be very influential in the decision-making process of the community. They are the gatekeepers in the community; those who want to work with the people in the community must connect with indigenous leaders to be accepted.

Connecting communities to resources through service providers and institutions is a property that describes another strategy for building a community's capacity for self-determination when issues and concerns identify the need for external resources. Connecting communities to resources provides community leaders not only with knowledge about opportunities for their communities, but also helps them to learn the tools and strategies of dealing with mainstream institutions. On the other hand, when mainstream institutions interact with communities this becomes a learning opportunity for them to see how communities work.

Mobilizing community action in culturally appropriate ways requires sensitivity and respect for indigenous ways of making decisions and working collectively. For example, democratic traditions defined in the western context may not be well-appreciated or well-developed in some cultures. Interventions for collective work must

fit within the cultural experience of ethnic minority communities. It can be a slow process of creatively searching for the appropriate combination of strategies. For example, in some communities where a sensitive issue such as youth crime is a common concern, people still do not want to talk about it. A big town hall meeting will not work in these communities, so indigenous community leaders are key to the process. Other means include the use of familiar forums in the everyday life of the community, such as small parties or religious ceremonies to introduce new knowledge or animate a discussion of community issues and concerns.

Table 13 Coding Process for Stage 3 "Brokering Support". Dimension 3: Building a Community's Capacity

Excerpts from interviews	Properties	Dimension
I do work with different communities in some degree of community development work… often communities that we currently don't have a broker and we have to still service those communities and we don't have the financial resources to hire colleagues to serve that community, but those communities needs attention. So often what I try to do is work with the indigenous leaders of those smaller communities and help them build up their own communities in a way to address the similar issues that we are dealing with as workers. Those are the three kind of clientele that I would describe: my own colleagues, the system, but also community leaders in other communities.	Partnering with indigenous leaders as partners in addressing community issues	Building a community's capacity for self-determination
It's the same with the community leaders who might come to us and say we're trying to work as a community to resolve issues around preventing our youth in entering into crime or joining gangs. Again, it's about piecing, seeking out powerful intervention that other people have used, and trying to see if even this intervention will fit this cultural context, right. Say, one of the southeast Asian communities is really concerned about their youth in crime, and yet the community really, so far, the parents don't want to talk about it. They just, every day they're fearful for their children, but they find it shameful to talk about it, and so you can't bring the community together. The leaders have to, kind of, work with one family at a time. And what we did, was try and look for good examples in the city where there other youth in, who had joined the gang, had found some good help, and we'll bring that person there to the leaders, and hopefully the leaders will, you know, mobilize the parents and work with them. But, every step is always a creative search for the right possible combination… and being able to facilitate the link and being supportive of the process of building communities.	Mobilizing community action to issues in culturally appropriate ways	Building a community's capacity for self-determination

Dimension 4: Catalyzing institutional change

Articulating the issues and struggles of ethnic minorities and how these impact their health and well-being is an essential first step in catalyzing institutional change. By nature, institutions are mandated to respond to the needs of the general population. Because of this, institutions become distant from the problems of communities who are small in number and that have unique needs that do not fall within the needs of the general population. Yet, these are the communities that will most likely be at risk for ill health. The multicultural health brokering practice assumes the task of informing and creating awareness and understanding among institutions about issues and concerns of those who are marginalized and isolated.

> Because, in some ways, I am a broker too, that is to broker the experience of health brokers to the system. So that the system begins to, not just kind of implicitly, oh, appreciate, oh you guys are doing a good job, but they literally deeply understand what the work is about and that the underlying issue is about inequities in the system that, you know. Many families, I think minority families already pay for service that they didn't really receive or if they received, it wasn't relevant or meaningful to them, right. And so, there is that issue. (Participant)

Enabling service providers to become culturally competent means creating positive relationships with service providers as a way of equipping them not only with the knowledge and skills for cross-cultural work but also helping them to appreciate cross-cultural encounters. The concept of cultural competence captures the range of competencies a service provider must develop in order to work respectfully and effectively with people from diverse cultural backgrounds. A person to be culturally competent must be aware of his/her own values and beliefs and how they influence his/her interaction with others, must know the values and belief systems of other cultures, must have the tools and be able to use them in understanding and responding to different cultural perspectives and lastly must be willing to interact with people from other cultures and learn from these encounters (Camphinha-Bacote, 1991). In Campinha-Bacote's model, the most effective way of developing the cultural competence of service providers is providing them with the opportunity to work in cross-cultural situations. However, according to one participant the only danger with focusing on developing cultural competency at the level of service providers is that once they leave, the institution goes back to where it was before. The need to advocate lasting

and enduring changes in the institutions is to begin at the level of policy. This involves developing cultural competence at the institutional level, which is the second property of catalyzing institutional change within the multicultural health brokering practice.

Helping institutions to become culturally competent is an expression of brokering support at the level of the organization. In the study, mainstream institutions such as the health system are viewed as lacking cultural competence. Their inadequacy is demonstrated in their ignoring that differences exist among populations and these differences affect the way people access health services and opportunities for sustaining health and quality of life. There are ideological underpinnings to this indifference – one is a hegemonic belief in the superiority of biomedicine which dismisses all other worldviews of health and healing as irrelevant (McKinlay, 1994; McKnight, 1993; Sanders & Carver, 1995). The other is a lack of awareness or perhaps naiveté about the increasing diversity of Canadian society, which will ultimately compel institutions to be responsive.

> ... but often in relation to the system, sometimes even to have to answer questions or deal with ideologies that are shockingly, deeply ignorant. For example, people will say why should we have immigrants, even though each of us came from families who were immigrants to a certain degree... and it's hard to work with all of the ignorance that we have combined. That leads to injustice. That leads to prejudice. That leads to inequities. (Participant)

Brokering support for institutions requires accessing resources for institutions to try to innovate and do things differently. This means working within institutions and being immersed in their culture and using this deeper knowledge to introduce change. Those who have chosen this path find themselves designing programs and services to demonstrate the positive impact of culturally responsive programs on the quality of institution-defined outcomes.

Advocating for changes within institutions is a complex act in the repertoire of brokering strategies. Advocating includes accomplishing concrete outcomes such as resources being allocated or new policies or programs implemented. The act of advocating has a powerful educative and conscientizing element within the institution that makes the change process profound and lasting. Advocacy always compels institutions to confront their own inadequacies. By nature, institutions will not readily

respond to being challenged, particularly when their systems appear to be threatened. There are some possibilities to explore for change happening in institutions based on the experience of several MCHBs who are working within the health system. One is to study and use the language that institutions understand. The other is to introduce incremental but cumulative changes that institutions can easily comprehend and appreciate. My own personal experience within the health system has taught me that an insider advocate needs to be immersed in the life and culture of the institution and to build trusting and supportive relationships before attempting to change it. Because of this, change can be a slow process and one nurtures all incremental movements, building on them towards progressive transformation.

Table 14 Coding Process for Stage 3 "Brokering Support" Dimension 4: Catalyzing Institutional Change

Excerpts from interviews	Properties	Dimension
Often, the running theme is about two sets of realities, not known to each other, primarily, of course, is the reality of ethnic minorities, the struggles, the difficulties, not known to the system. It's very much about revealing a set of realities that's not known and, by not knowing that reality, inequities exist because of that not knowing. And so, in so many ways, it's the function of making it be known to each side, but particularly for the system to know about the struggles of the ethnic minority families, but further to that is to mediate and bring about change no matter how long it might take…	Articulating the issues and struggles of ethnic minorities	Catalyzing institutional change towards cultural competence
After two days to visit the family, this social worker started to understand the difference between interpreter and cultural interpreter, then she appreciated it. Back to us again, if she treated you rude and you treated her with respect in return, then she changed her attitude, she changed her attitude the third time we visited the family. She appreciated our help, and it was a reward after that. Although, I'm not patient sometimes, but I knew that I had to act professionally. *That was something that I felt good about contributing, and also Capital Health has been accredited and I was in one of the teams for primary about teams that they have, that specialize in public health, so that was good, and I think that I see that as my role to represent multicultural health brokers, advocate on their behalf, let the populace know that we exist and what we are doing, and it is a good way to let the other service providers know about our program care for hard to reach populations, and it makes me feel good that we have an action plan, like our team has recommended translations, and also multicultural health brokers have been mentioned many times…*	Enabling service providers to become culturally competent Helping institutions become responsive to cultural diversity	Catalyzing institutional change towards cultural competence

Table 14 Continued

Excerpts from interviews	Properties	Dimension
I've come to believe whatever issue exists in the community, unfortunately, there is a systemic element to it… As a health broker... we also have a mandate around helping the system change so that they become more responsive. But as an organization, the health brokering practice, it is meant to be multi-faceted, but also multi-leveled, so that it deals not only with, on a micro-level with each family, it does look at building communities and at the same time it's an ambitious promise, which is to support the systems to change too.	Advocating for changes in the system	Catalyzing institutional change towards cultural competence

Stage 4 : Achieving equity of access to health

Achieving equity of access to health has 12 properties expressed in the following dimensions:

Dimension 1: Providing one-on-one support

Short-term outcomes

- Access to services for promoting & maintaining health
- Resolution of presenting or immediate issues

Long- term outcomes

- Becoming autonomous, independent and empowered
- Beginning to address underlying or deeper issues

Dimension 2: Building supportive groups

- Increased opportunities for social interaction
- Access to resources for group development
- Feeling of self-worth

Dimension 3: Building a community's capacity for self-determination

- Increased community's access to resources and opportunities for well-being
- Collective sense of belonging and of being valued

Dimension 4: Catalyzing institutional change

- Institutions recognizing needs of ethnic minorities

- Improving service to meet diverse needs
- Service organizations open to a community's way of doing ("a sense of community development")

Dimension 1: Providing one-on-one support

The short-term outcomes are those that were achieved as a result of initial intensive support, particularly when the initiation stage is an urgent crisis situation. For example, securing housing for an immigrant woman leaving an abusive situation is a result of intensive brokering work that involves gathering information, providing emotional support, mediating with family members and service providers, providing emotional and practical support and then connecting the woman to the appropriate services. Less intensive support includes providing health information in the first language, getting people to participate in health-promoting programs and then linking them with relevant service providers. These short-term outcomes contribute to achieving equity of access to health when immediate and presenting issues are resolved through a resourceful navigation of the system.

Long-term outcomes are those that engaged individuals in the participative process of problem-solving and solution-seeking, intended to incrementally build their capacity to be independent and autonomous. Achieving equity of access to health at the level of personal care is about enabling individuals and families to recapture their sense of purpose, to be resilient in the midst of adversity, to act independently with full recognition of their rights (and their own power) and to seek redress of inequities impacting their situation. Some specific actions that contribute to long-term outcomes at the level of personal care involve creating opportunities where clients increasingly become more self-confident to deal with their own issues; securing support that addresses the determinants of the clients' issues such as employment, housing, food, security etc. and creating awareness about the larger factors that affect the clients' issues.

> When the women and the babies are healthy and doing fine and the women know what to do with the baby and if the husband already has a job and he's well established, then I encourage them very much into self-awareness… to make sure that they feel proud of themselves in a way, that they are able to face racism, … I try to help them out to understand that racism is not a problem (about themselves) but somebody else's problem... it's about other people who have to deal with their own personal things and they (clients) are OK with the way they are, that we are all different and we are all human, and that's actually powerful. Cultural brokers don't just deal with the surface but delve deeper into the underlying cause of the problem. (Participant)

Table 15 Coding Process for Stage 4 "Achieving Equity of Access to Health" Dimension 1: Providing One-on-One support

Excerpts from interviews	Clustered open codes	Dimension
... to have healthy people without having any health problems. If a woman is pregnant, I help her to have a healthy pregnancy, a healthy baby delivered after... My goal is to have the people satisfied, healthy and understand what the services are there for them. I like to see the people independent that they can arrange for themselves. *I'm hoping that least we are able to deal with the service issues, that people, at the minimum, gain access to mainstream resources and services that are really their rights. It might not have solved the core problem, but at least for the service issues we have been able to help people gain access to what they deserve.* *Some of the moms in the beginning who didn't want to come out are right now got others to come... Now they're also helping other people.*	Short-term outcomes • Access to services for promoting & maintaining health • Resolution of presenting or immediate issues	Providing one-on-one support
When you have new information...something new, call me'...bring to them hope and also empower... The potential, or their own strength, they can develop their own strength to help themselves, also help others, so I don't want to be a central (figure). *I know the clients no longer needs my service when they don't call me anymore or they don't show up. They are independent and on their own.* *When the women and the babies are healthy and doing fine and the women know what to do with the baby and if the husband already has a job and he's well established, then I encourage them very much into self-awareness... to make sure that they feel proud of themselves in a way, that they are able to face racism, ... I try to help them out to understand that racism is not a problem (about themselves) but somebody else's problem... it's about other people who have to deal with their own personal things and they (clients) are OK with the way they are, that we are all different and we are all human, and that's actually powerful. Cultural brokers don't just deal with the surface but delve deeper into the underlying cause of the problem.*	Long-term outcomes • Becoming autonomous, independent and empowered • Beginning to address underlying or deeper issues such as racism, marginalization, etc.	Providing one-on-one support

Dimension 2: Building supportive groups

Achieving equity of access to health within a group context is about social inclusion. To be included is to be accepted and to be able to use one's gifts to share with others. For ethnic minorities, it is about regaining their feelings of self-worth, which they have lost when they moved into a society that has shown little appreciation for indigenous skills. The people who come to these supportive groups achieve a feeling of self-worth, especially when they are viewed not as persons in need but as people who can support others. In the multicultural health brokering practice, groups achieve equity of access to health when they feel a sense of control and when they are given the chance to participate and shape the structure and direction of their group. Whether the choice was to use the group as a venue to sit and talk with each other or to venture into activities for self and group improvement, the group members feel that they were recognized, valued and in control.

Table 16 Coding Process for Stage 4 "Achieving Equity of Access to Health" Dimension 2: Building Supportive Groups

Excerpts from interviews	Properties	Dimension
It was when the group really started to come together. It was us flexing to what they wanted. I think we were thinking well we wanted it to be structured so that the group can have information but how do we present to them. They really wanted a piece of it to sit and talk to each other. You know just to be together - and have a bit informal to each other. It was a learning for us to allow it to happen.	Increased opportunities for social interaction	Building supportive groups in ethnic minority communities
... in our drop-in, we don't only do Health for Two, but we have Rhymes that Bind program, we have Mobile Library, we have Health Talk, and we also have children's program, so there's quite a variety of services here, so the moms not only come here for pregnancy support, but they also come here for parenting issues, they come here as a social gathering and besides the drop-in, we also run a collective kitchen, so some of the moms, they can just stay together and go to the kitchen.	Access to resources for ongoing group development Feelings of self-worth and being part of a group	

Dimension 3: Building a community's capacity for self-determination

A collective sense of belonging and of being valued among ethnic minority communities is perhaps the most significant outcome of achieving equity of access to health. The feeling of being valued means that one's contribution in a collective

undertaking is important, especially when it has made a difference to others. For communities that have experienced prejudice and discrimination, being valued also means being included or accepted. A feeling of belonging focuses the community's energy towards building its own capacity to be autonomous and to enhance its social capital. Social capital is a concept that is founded on strong mutual relationships among community members that allow them to resolve problems together (Ricks, Charlesworth, Bellefeuille, & Fiekd, 1999). Social capital is the bond created by communities that brings people together and enables them to undertake co-ordinated action. For economically disadvantaged communities, social capital is perhaps their only and most important resource that they can mobilize to gain access to opportunities for community health. For ethnic minority communities, the social fabric is the personal and social relationships they have built amongst each other and which are strengthened by their cultural traditions. Multicultural health brokering draws upon this social fabric to create the social capital needed by communities to achieve equity of access to health.

Table 17 Coding process for Stage 4 "Achieving Equity of Access to Health" Dimension 3: Building a Community's Capacity

Excerpts from interviews	Properties	Dimension
One is a business venture; where we are exploring a business that can sustain the co-op, create opportunities of work for people in our own communities… I'm involved with the city of Edmonton in a larger project that is an international marketplace,...an opportunity to involve the members of the communities purchase a small business.	Access to opportunities for community members' well-being	Building ethnic minority community's capacity for self-determination
Helping community leaders to create moments of, sense of camaraderie, a sense of not being alone, a sense of valued so that people can continue to stay in the struggle for the rest of the week.	Creating a sense of togetherness and of being valued	

Dimension 4 : Catalyzing institutional change

Catalyzing institutional change to achieve equity of access to health happens when institutions begin to recognize that ethnic minority populations have unique needs that are different from the larger majority of the population. These needs are expressed as barriers to accessing services and resources when ethnic minority communities try to attain optimum health and well-being. Being aware of the barriers is a critical first step for institutions wanting to provide better programs and services.

When service organizations are opening up to the "community's" way of doing things, they are in fact promoting equity of access to health. By being inclusive and allowing community members to participate in making decisions about programs and services, service organizations welcome the challenge that the process may not be "straight and narrow", but circuitous and ambiguous. By accepting that the key element in this process is learning and growth, service organizations are gradually building their participatory capacity.

Table 18 Coding Process for Stage 4 "Achieving Equity of Access to Health" Dimension: Catalyzing Institutional Change

Excerpts from interviews	Properties	Dimension
Some of the grassroots organizations that are also immigrant-serving, we're helping them become more deeply aware of the issues in immigrant communities. So we have organizations to serve immigrants, but over time have become a bit removed from the people… we're helping them because we're in direct contact with the people and because my colleagues aren't like other workers of the grassroots agencies, where they're only allowed to do certain things, we're able to see the full scope of what people's lives are like. So, in some ways we've become the informants, and sometimes even the brokers for immigrant-serving agencies.	Institutions recognize unique needs of ethnic minorities	Catalyzing institutional change towards cultural competence
For big institutions that we've been working with for almost ten years, it's always encouraging when they finally say, carve out some internal budget to keep a position permanent, a position that we helped set up as a pioneer project. And so these are all a sign of incremental changes. It's mostly around agencies or organizations finally recognizing, learning about what is needed in the community and responding to it, and having direct relationship with the communities. Those are all good things that happened through our involvement. And so, we literally played the brokering role, again, in bringing, creating relationships, bringing resources sometimes to people to dare to try something new in terms of decision, or in terms of working with a community group.	Improvement in services to meet needs of culturally diverse populations	

At the level of systems and policy, achieving equity of access to health necessitates that the multicultural health brokering practice to act beyond the presenting issues such as lack of access to programs or services and connect these issues to larger, underlying factors in society such as social inequities that are causing these problematic

conditions. Achieving equity of access to health is about addressing the broad determinants of health, but beyond that it is about social justice.

> Whether they're, it's about teen or about very lonely seniors, immigrant seniors, or about women who are the most marginalized immigrant community, it speaks about power, it speaks about lack of power, it speaks about some in this society still are more valued than others and, and it speaks about people not feeling, basically, valued, that they are not living their lives to the fullest with the greatest amount of dignity, you know, based on their own talents and strengths, those talents and strengths are overlooked, they're looked upon for other, you know, or measured up in accordance to certain other dimensions, you know, colour of their skin or having born somewhere else, or speak another language, you know. And so the themes are so resoundingly common across the communities that in the end, that there's maybe only one issue, is that, we still haven't found a way to create true justice in a diverse society... (Participant)

However, this is an arena of work that not all multicultural health brokers are comfortable with for many understandable reasons. First is the lack of resources when only a few multicultural health brokers are already responding to an increasing number of individuals in need.

> Because that's one of our articulated promises, but it's not easy, like, when we're all so overwhelmed because of lack of resources, we're just running all the time with adrenaline, to just keep preventing crises or putting out fires. I don't think we have yet found the time for us to truly take the time to build other people's capacities. We talk about it. We use the term empowerment. So there are a lot of hopes and promises that we talk a lot about, that we believe in, but just because of the reality of not having enough resources, not having enough colleagues to go around, and the problems are escalating, rather than, you know, in terms of number of families in a community or new communities becoming a part of Edmonton, that, at best, we're probably just preventing crises, and, at best, slowing things down a little bit. (Participant)

The second is that this kind of broad-level brokering work requires certain skills and knowledge such as policy development, political advocacy and coalition building that most multicultural health brokers have no formal training nor experience with.

> Sometimes I feel like this whole complex issue of lack of equity or social justice or issues of discrimination, it does require, maybe some kind of wisdom that you can only acquire if you are over a hundred years old. That there's a kind of sophistication and maturity that I don't think again, any of us truly deeply have yet. (Participant)

Those who have taken up this broader level of brokering work in their practice are involved in engaging institutions and organizations in the discussion of larger issues. These multicultural health brokers take these discussions in boardrooms and conferences where the multicultural health brokers are articulators of inequity and injustice.

> It is sad to say that, but it's an unfortunate reality that we are living with. So I am hoping that, at the minimum, aside from putting out fires and preventing crises, at the minimum, we're spreading the message broad enough that some critical people in the system as well as people in our own community are beginning to say, hey, we do have problems and those problems are because of this. We hope we're doing that. In no way can sixteen of us, change society... (Participant)

Examples of the multicultural health brokering practice working at a higher level of systems and policy, seeking avenues where issues of inequities for ethnic minorities can be brought forward are: linking resources to institutions so they can demonstrate strategies to improve access of marginalized populations to their programs and services, and building coalitions with those who share the same passion and commitment to equity and social justice.

The fifth dimension: building solidarity with broad-based organizations

The grounded theory of multicultural health brokering revealed only four dimensions of the practice, based on the data generated by the research participants. The factors that determine the health of ethnic minorities discussed in the first chapter of this study reveal there is a larger arena for achieving equity of access to health beyond the individual, group, community and institution. This is the arena of social change and involves the creation of a critical consciousness on issues of power, inequities and injustice.

However, this goal is larger than what the multicultural health brokers can do. To accomplish social change, the MCHB practice must have an organizational vehicle that has a collective mandate to advocate with the communities it is serving, as well as the ability to leverage resources for creating change in the larger society. From a strategic vantage, the multicultural health brokering practice must begin to operate in the fifth dimension of building solidarity with broad-based organizations that have the resources and capacity to mobilize actions that would have societal impact. This fifth dimension is a crucial role that the Multicultural Health Brokers Co-operative should begin to explore. It will take multicultural health brokering work to the broader realm of social transformation. It becomes an inevitable task that the Co-op should seek solidarity with those who share and commit to the ideals and vision of social justice and human rights

After all, these are the very foundations of a healthy and thriving society (Evans, Whitehead, Wirth, & Epstein, 2001).

V. Defining the multicultural health brokering practice

The grounded theory on multicultural health brokering generated from the research provides a basis for generating a definition of the practice. The definition presented in this section addresses the purpose of this research, which is to "systematically describe and define" the multicultural health brokering practice. Based on the theory developed, multicultural health brokering is a holistic and relationship-based practice of building connectedness and brokering support for individuals, families and groups from ethnic minority communities to achieve equity of access to health. It is a multi-dimensional practice that involves providing one-on-one support for individuals and families, building supportive groups, building a community's capacity for self-determination and catalyzing institutional change.

Multicultural health brokering adopts a holistic approach to explore the issues of individuals and families within their social and cultural context and as such provides interventions that respond to immediate issues that also address underlying conditions and circumstances. It is a relationship-based practice that acknowledges the knowledge, skills, talents and gifts of people and communities as vital to the process of providing support and seeking solutions to problems. Multicultural health brokering is based on the principle of reciprocity and equality; multicultural health brokers work with individuals, groups and communities as partners or allies in the act of creating change to improve individual circumstances and build communities capable of realizing their goals and aspirations.

Multicultural health brokering is aimed at achieving equity of access to health for individuals, families, groups and communities who have limited opportunities for responding to their health issues or maintaining and supporting their quality of life and well-being. The arena of multicultural health brokering is built around providing individual care but also extends to supporting groups by creating a sense of togetherness, enabling communities to gain the ability and confidence to solve problems

and fulfill aspirations, and to work collaboratively with institutions to adopt equity-oriented policies, programs and services.

VI. Defining what makes a multicultural health broker

The definition of the multicultural health brokering practice implies a multi-faceted role for the multicultural health broker, and likewise suggests a diverse set of knowledge, skills and personal orientations. The study also included questions about what qualities make a multicultural health broker. Overall, the participants believed that a multicultural health broker is someone who possesses at least two sets of differing cultural knowledge, multiple skills and a genuine love for people. In particular, the participants identified three areas of competence for multicultural health brokers. The first is a set of knowledge about two cultural systems that the MCHB will be working with – in this case that of her/his (MCHBs) own culture and the formal health system that includes the beliefs, norms and traditions of service providers operating within that cultural system.

> A cultural broker must have knowledge of both cultures, the health system in Canada, resources (what is available for those in need), social policy, the health system back home. (Participant)

> Because of the strong sense of the value system or the depth of understanding of my culture, I'm able to deal with people from other cultures because I have an appreciation of their culture and their values that come out of that. Working with service providers, because it's a... because they have a culture of their own too... institutions have their own culture, so it's... I'm always trying to learn the value system that comes with that, and then I'm able to bridge, hopefully, sometimes I have to advocate on behalf of the minority culture. (Participant)

Knowledge of the mainstream culture system allows the multicultural health brokers to identify resources that they could access to support the clients and communities they work with. Having a good understanding of the mainstream culture system increases the brokers' effectiveness in building relationships among service providers who will be potential allies and champions for introducing improvements in programs and services.

The second set of competencies is around a skills set that would contribute mainly towards them performing their roles as brokers and mediators of information

and knowledge. Most of the participants mentioned teaching, relational skills and problem-solving as important skills for an MCHB to be able to transfer knowledge from one culture to another.

> I think teaching, oh yeah, that is most important. If you don't have the teaching skills, then no matter how much you know but if you don't know how to deliver that message, people wouldn't understand, not only understand but wouldn't be interested in capturing your message, so I think you have to be interested in teaching people, you know talkative, not too much because sometimes if you talk too much, people wouldn't like you anyway, but sense of humor, I think when I teach of people, you have fun and you kind of know how to deliver information and you are sensitive of the people, whether they are sleepy, you must have that skill. (Participant)

> It's good to have people skills, you know, people who are comfortable working with people, not a person who wants to work in front of a computer or a research lab only. (Participant)

The third set of competencies are personal qualities that the participants believed to be crucial in ensuring that the multicultural health brokering practice achieved its desired outcomes. Most of the participants agree that a strong belief in people, a compassionate heart and emotional maturity are the essential qualities of a multicultural health broker. This is because the MCHB deals with many issues that are complex and overwhelming. All of the participants have experienced having provided support to many families that are experiencing health issues associated with multiple layers of social and economic circumstances such as poverty, breakdown in family relationships and social isolation. For example, it is not uncommon for a multicultural health broker to work with a depressed pregnant mother who has never been out of her house since she arrived in Canada, whose husband is unemployed and who may have younger children with problems in school. The multicultural health brokers must have faith in people's capacity to be able to nurture an empowering process. This is for individuals and families who have lost all sense of control over their lives.

Emotional maturity is needed to help this pregnant woman (and anyone else) get through the frustrations of working with systems that are oftentimes rigid and unbending to people with special needs.

> A strong belief to help people. If you don't have that, you can't do the work... Reflecting on my own experience, I think that for me, the fact that I like to help people basically, that I believe that everybody has the right to live a full life. (Participant)

I said the personal qualities there, to have the heart in the right place. Compassion is very important, the ability to walk a mile in somebody else's shoes. (Participant)

You know, if you asked me how to define maturity, I think maturity is greatly needed in this kind of work It's almost a sense of transcending, being able to transcend the struggles at the moment, to kind, you know, as I mentioned, to recognize it's nothing personal, it's part of the job. It's nothing personal, it's part of the dynamics. Not only should I understand it, I should anticipate it, and in anticipating, maybe I could prevent some of the painfulness of human conflict, right. Or to anticipate, yeah, people will say things that are totally shocking that is highly discriminatory, but perhaps that's because he or she didn't know about this reality, right. And so, in the maturity is a degree of transcendence and a degree of clarity of mind, but also a whole lot of forgiving. You know, you move through the day and you were, felt really, really hurt in that situation, you not only do you transcend it to say it's part of the job, but you, literally you forgive. Tomorrow, when you see the same group of people, you've already forgiven them. You move on and you continue to work in a very disciplined manner, right. And so, I guess this kind of emotional maturity is very important. (Participant)

It's almost required of the broker, of course it's wonderful if a broker had experienced some, quite a degree of difficulties in their life, that might be a helpful thing, but it's really, in the end, it's someone, if they had experienced difficulty, had actually worked through it, no longer trapped in the emotions or the disappointment, that it, if there are, you gain power from transcending that struggle. Or, if someone hasn't experienced a lot, still knows what it's like to be forgiven, forgiving and to move on, to be totally committed to something greater than me, greater than her, greater than her. It's about, very clear, about a greater set of objectives you're striving for and often for the good of the people, right. And so, it's a lot of letting go of one's sense of self, to a degree, not to be so focused on, oh, are people recognizing that I'm doing a good job, or are people, are people talking about me today. You can't, you get so quickly absorbed in disappointment that, you know, you can't survive for very long. So I think, maturity, hopefulness, um, an interesting combination of intellectual clarity, but also be genuine with one's emotions, right. Those who are too intellectually clear and somewhat removed emotionally, might find it difficult, because you couldn't engage the clients. (Participant)

From the point of view of the participants, not everyone can do the job of a multicultural health broker because the demands of working intensively with individuals and families requires not only the appropriate knowledge and skills but a certain personal orientation, to a large extent a passion to work for something greater than just resolving a specific issue occurring at the moment.

I literally watched my colleagues walk into a room, there's instantaneous trust. Somehow they have projected a sense of warmth and genuineness that people responded to. So, it's something that you, I don't think you can learn. You can't pretend. You have to be real. And you have to be real in your care for the people. And I think as human beings we sense it. We don't have to talk about it, you don't have to, you know, write about it. People know it, whether you have it or not. And so, those are important qualities. (Participants)

The literature on lay health workers confirmed the emotional demands of working with individuals and families with difficult circumstances, and balancing this with their personal lives. The personal challenges of community health workers (CHWs) add another compounding stressor, such as difficult life circumstances similar to their clients, which may reinforce their personal inadequacies and increase their personal and family stress (Ramirez-Valles, 1999). Some CHWs have experienced moments of being "burnt out" stemming primarily from the complex health-related social issues of their client as well as their own personal problems.

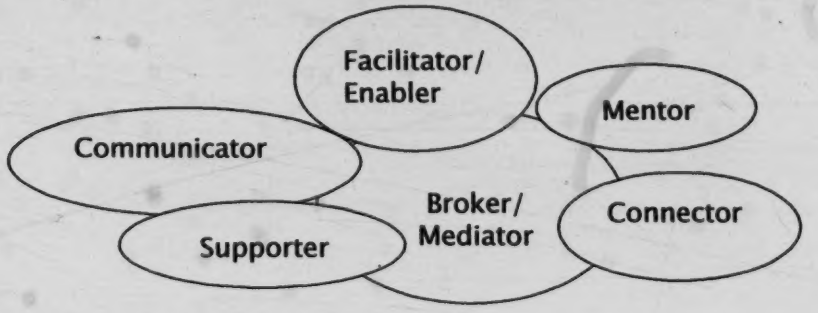
This view is consistent with the progressive stages and multiple dimensions articulated in the multicultural health brokering theory. The stages in the theory reveal processes that require someone who is knowledgeable and comfortable in working with two cultural systems and a skills set that enables him/her to navigate the web of supports and resources, available in those systems. Most of all, the broker needs the facility to access these supports and resources including overcoming barriers in getting them. The mediating role of the multicultural health broker is expressed by bridging between two differing cultures – those primarily of the ethnic minorities and those of mainstream institutions. To be able to achieve successful bridging, the multicultural health brokers must experience the act of facilitating or enabling the expression of hopes and fears, communicating or sharing information about two knowledge systems (often in conflict) to arrive at a mutual understanding of these two knowledge systems; connecting resources and opportunities, mentoring to build and strengthen capacities and lastly by being supportive of people in need or in distress.

The four dimensions within the multicultural health brokering practice specify multiple roles for the multicultural health broker. In providing one-on-one support, the MCHB is the counselor and mentor, guiding individuals and families and working through the resolution of issues. In building supportive groups, the MCHB is the teacher/facilitator where group participants look up to her/him for knowledge and support at the same time that she/he is also creating opportunities for personal growth and development. In building a community's capacity for self-determination, the MCHB is the community organizer who uses the tools of community development to mobilize and engage community members in collective solution-seeking. In catalyzing

institutional change for cultural competence, the MCHB is the policy advocate who seeks to inform and arouse institutions to be creative and innovative in responding to issues of diversity and equity.

Thus, the multidimensionality of the multicultural health brokering practice described in the grounded theory identifies three areas of competence for a multicultural health broker: a knowledge base that must progressively accumulate, a skills set that is continuously strengthened, and personal qualities that are increasingly enhanced by working with people. In other words, the multicultural health broker's effectiveness is an outcome of his/her continuing effort at learning the craft of brokering but also the unstinting commitment to personal growth. The multiple roles of the multicultural health broker are centred on the role of a broker/mediator, with supporting functions as shown in the following diagram. Figure 13 illustrates the broker's multiple roles.

Figure 13 Multiple Roles of a Multicultural Health Broker

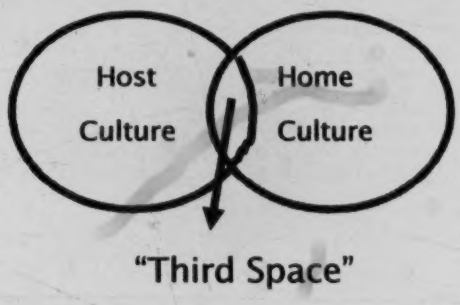


McLeod (1981) presents an interesting framework when describing a mediating person, which this study has adopted in discussing the participants' view of what makes a multicultural health broker. In her framework, the mediation person can be viewed in three domains: who the person is (personal attributes), what the person does (functions);, and how this person is socially regarded (ascribed attributes or socially defined roles). The basic assumption in the concept of the mediating person is that she/he is located at the conjunction of two or more cultures and that the mediating function will result in benefits to the home culture, the host culture or to society in general (McLeod, 1981).

This concept has anthropological roots; in Newcomb's concept of the cultural broker as a marginal person (Press, 1969). The marginal person is one who straddles two cultures and operates at the borders of these two cultures. McLeod's (1981) assumptions are relevant and applicable to the theory of the multicultural health brokering practice. In this practice, the differing cultures broadly refer to the ethnic minority cultures (home culture), the Euro-Canadian majority culture represented by institutions (host culture), and the diverse Canadian society. In fact, multicultural health brokers often refer to themselves as being in the "third space"; that invisible area between two cultures.

> And so, again, as the kind of the person in the middle, or operating in the third space, you're really relying on information about both sides that you know. And sometimes tapping into your own experience interacting with the system or being part of that community. (Participant)

Figure 14 The Third Space of the Multicultural Health Brokering Practice



There is an assumption in grounded theory that the outcome of the multicultural health brokering practice will be beneficial to ethnic minorities by achieving equity of access to health, to the mainstream institutions by ensuring culturally responsive programs and service, and to Canadian society by reducing conflict and tension.

First domain: Personal attributes

McLeod (1981) lists three attributes of the mediating person: knowledge and experience, cultural identity and task or social orientation. Extensive and intensive knowledge of more than one culture both at the cognitive and affective level is vital to the mediating function. Cultural knowledge can be defined as historical, such as social

heritage or traditions; normative rules and ways of life; psychological, or why people think, act and feel the way they do; and structural, referring to patterning or organization of culture (Camphinha-Bacote, 1991). The mediating person is expected to be knowledgeable in these areas of cultural knowledge to be able to share information and teach people about each other's cultures. This knowledge can be obtained by either birth and socialization or through formal training and education. In the study, the participants believed that a multicultural health broker should be knowledgeable about the cultures they are mediating. Even if all of them were born and raised in their home culture, they strongly indicated that a multicultural health broker should still continue to learn about their own culture because even traditional cultures change over time.

> Well... you are born into that culture and there is culture ingrained in yourself, you don't really go and out and learned about it, you live it up and it's evolving and the culture doesn't stay the same. It's evolving and things change and we just keep up with that. (Participant)

According to McLeod (1981) the mediating role also requires competence on the culture of mainstream institutions, including the values, beliefs and the rules that guide their actions and the social expectations of members of their culture. This knowledge is particularly important when facilitating connections and accessing resources from these institutions. The participants mentioned this knowledge as crucial to their functions as multicultural health brokers.

The affective level of cultural knowledge involved speaking and behaving appropriately in each culture and being familiar enough to be non-threatening (McCleod, 1991). This is a necessary requirement for building trusting relationships crucial to effective mediation. Empathy was identified by most of the participants as a quality that multicultural health brokers must possess in order to serve the mediating/bridging function. Empathetic listening is one of the properties of Stage 2, which is building connectedness in the theory of the multicultural health brokering practice. Empathy is expressed as sensitivity to the feelings of people, the ability to put oneself in their position, to construct the world as they do and to experience behaving and feeling as they do (Taft, 1981). From the multicultural health brokers' experience, empathy does not come from being born into a culture, although this is important, but it

comes more from sharing the same life experience with that of the people they serve.

> A cultural worker's best quality is his/her own life experience- one's self. It is what allows you to gain an empathetic point-of-view towards one's clients, which they really appreciate. People know that you understand where they are coming from because you lived and experienced the same thing. You must be able to know how to deal with people on every level (social, political, personal, official)...Especially if you know what it is like to be in their shoes. We were once in the same boat- the war, and refugee camps. I know the immigrant experience and that makes it easier for me to understand and help. To best help someone, I need to understand his or her problem. (Participant)

Cultural identity means the mediating person's comfort and security with his/her identity as a person. This refers to which group he/she considers being a member of – whether it is the home culture or the host culture or both. Biculturalism is a competence that few individuals possess. It is the quality that allows a person to move from one culture to another because he/she has sufficient knowledge and experience in both, including linguistic competence and cultural competence. Multicultural health brokers speak about bicultural skills as a critical attribute:

> And so it's a combination of being bicultural bilingual, I guess, in that sense, not specifically language, in the sense of language, but knowing two cultures, nurturing relationship, mediating cultural differences, at times often advocating, fighting, with the system, challenging the system for the sake of the best outcome for the people. (Participant)

In the many conversations I had with the research participants, they considered themselves first as members of their ethnic/cultural communities and second as members of Canadian society. All of them were born and raised in their home country (except for three who came to Canada when they were young). They have spent a large part of their adult life in Canada and have learned the language and the Euro-Canadian majority culture. According to McLeod (1981), bicultural individuals often make the best cultural mediators.

Personal orientations are important attributes for the mediating person in McLeod's framework and are also identified by the research participants as a key competence of the multicultural health broker. Whether a person is task-oriented or more socially oriented will influence the mediating process. In an ideal world, the mediating person should have a good balance of task and social orientation. The ability to relate and interact positively with people creates a favourable atmosphere for bridging and mediation, but a mediator must also have the ability to carry through the

purpose of mediation. For many of the participants, someone who has social skills or what they termed "people skills" are qualities essential to multicultural health brokering work. Someone who is warm, open and friendly, who sparks instant rapport when meeting with people for the first time and who enjoys working with a diverse group of people. Most participants said that these people skills emanate from someone who is genuinely caring and compassionate; "whose heart is in the right place".

Second domain: functions of the mediating person

The second domain of the mediating person's attributes involves the functional attributes. Taft (1981) defines a cultural mediator as a person who "facilitates communication, understanding and action between persons or groups who differ with respect to language and culture" (p.52). This definition resonates with what the research participants perceived to be the foundational role of a multicultural health broker. Whether the arena is the home, clinic, community or an institution, the multicultural health brokering practice involves communicating, bridging/mediating, negotiating and advocating to create a mutual understanding of two different cultures. The ultimate outcome of such understanding is to direct resources and opportunities to people and communities in need.

Communication skills are considered vital to the performance of the multicultural health brokering functions. The participants agreed that language proficiency in the home culture and the host culture, in this case English, should be a primary skill requirement for a multicultural health broker. They also mentioned that it would be to the multicultural health brokers' advantage if they knew at least two dialects of the home culture. This is because most countries would have two or more dialects that identify specific geographical regions. Communication skills also include non-verbal language and other forms of expressions and interaction among culture. The participants indicated that one of the greatest advantages of being born and raised in the culture of the community they serve is that they are able to understand meanings of gestures, cues and body language that outsiders may not be able to observe and detect.

> Part of being a multicultural health broker for immigrants from the former Yugoslavia means you have to be extremely sensitive and careful in terms of what you are and aren't allowed to say. You have to pay attention to how you ask questions. To avoid the controversy over ethnicity or language, I usually say "I speak your language" instead of

> Serbo-Croatian. So part of my job involves knowing this political issue and having the knowledge and skills in how to deal with this. (Participant)

It is also important for multicultural health brokers to learn about medical jargon, the characteristics of professionals within the health system and how they interact with each other. This comes from learning about their world and interacting with them on a regular basis.

Educative skills are one of the skills mentioned by the participants that will enable multicultural health brokers to create or seize opportunities for learning. A significant portion of the multicultural health brokering practice involves sharing of information, changing attitudes and promoting self-sustaining behaviours and actions. This is an educator's role; knowledge is a foundation for change in attitudes and behaviours. The participants mentioned technical skills, particularly in the area of health and early childhood development, as being necessary for the them to be able to perform the task as educators.

> I am happy when I see the people can be independent, when I know that the person knows something and then they can do by themselves. (Participant)

> I think it is very rewarding because we know the moms, when they are still pregnant, now the kids are growing, and you see them learning something from our drop-in, because we can see the big difference that the kids make, they learn to be social with other kids, listen to their teacher, things like that. (Participant)

> The most rewarding part of my job is seeing change in a client's life. When I see that a client gets well because of the job I did, whether it was through an orientation or other services, it makes my job worthwhile. (Participant)

McLeod (1981) refers to the "teacher" as the true mediator because the outcome of mediation is "measured in terms of what is learned by those with whom he/(she) has contact" (p.40). It means that a successful mediating effort is when members of the two cultures have gained a greater knowledge, empathy and respect for each other as a result of the actions of the cultural mediator. Whether they are professionals or non-professionals, true mediation assumes a teaching role – "acting as a channel of information and an aid in the development of humanitarian attitude"(McLeod, 1981p.41). It is interesting to note that many multicultural health brokers were teachers in their home country before they came to Canada.

Third domain: Ascribed attributes of the mediating person

The last domain of the McCleod's (1981) mediating person's attributes involves ascribed attributes or socially defined roles. Of all the attributes and characteristics of a mediator, the most crucial determinant of success is whether he/she is accepted or rejected in his/her role by both of the two cultures concerned. Is cultural mediation possible if the mediator is rejected in even one of the cultures? In the experience of the participants, acceptance in both cultures was indeed critical for them to be able to build trusting relationships and to negotiate access to the necessary supports they needed for their clients. Within their communities, the multicultural health brokers enjoy the advantage of sharing the same cultural background and has contributed to the continued support of members of their communities. The increasing number of community referrals to the multicultural health brokers is proof of the trust that the community holds for them (Multicultural Health Brokers Co-op, Annual Report, 2001).

Recognition of the health brokers' practice by institutions and in their communities is pivotal in the co-op's success:

> The nurses were like that (unsupportive) at the beginning. They didn't want us there. We did actually a lot of advocacy and not what we have today, brokers that are into pregnancy and things like that, because the work that we do, it just wouldn't happen out of the blue, and it was a very tough environment, because they didn't understand what we were doing and they thought that we were taking their job, like they say "Why do we need a health broker". We had a second title, multicultural health developers, and then finally multicultural health brokers, and then at the time, I remember that the nurses were telling me that "Yeah, you could do this in your community, but this has nothing to do with me", you know, that was their response, if you do it in your language, that's fine, but here, we don't need you, you know, and we got them as an associate for years. As a health developer, that was worse, because they thought that we were taking their jobs away, and there were a few offers to be part of their system, but we rejected them, because we thought that we would be sucked by their system and then we won't be able to work the way we do, and that wasn't really very supportive at all. Over the years, things changed. I think that we opened that change, that door with our own jobs, with our advocacy that we did before for the brokers today, it changed a lot because you know, by giving presentations, by showing them "yes we can" and "yes we can do work together" and "we know how to do this and please trust us" and bridging between them and the culture and the service that they provide, anytime that they need us, we were there, and then suddenly, they switched, and their mind started to say "Oh, what would we do without you guys in here" or "How can I deal with this terrible case". (Participant)

The gradual acceptance of the multicultural health brokers within the area of perinatal health was the result of a long-term effort. For many years, the MCHBs struggled to gain acceptance for their work of helping ethnic minorities gain access to health services. With the continued commitment of the regional health authority in Edmonton supporting the work of the multicultural health brokers, the MCHBs have expanded their services beyond perinatal health to include early childhood development and early intervention (Multicultural Health Brokers Coop, 2001). Despite this, the participants felt that this support has not created the institutional environment necessary to sustain the work of multicultural health brokers in other parts of the health system. For example, the perinatal health project in immigrant and refugee communities is still not part of the regional health authority's core budget. The MCHB Co-op has to renew its contract every year with the regional health authority, subject to the availability of funds.

Without a professional discipline, the MCHBs are still marginalized workers in the health system, seeking full recognition of their potential to contribute to positive health outcomes.

> You know, they would, you know, something very practical is that you may be just playing the role of an interpreter in a particular situation, even though you're working as a broker, and the health provider or the professional will later say, you know, I'm not trusting you, because in the process you were saying a lot to this family. Were you encouraging them to choose a certain course of action? And that kind of, I guess, it comes with the job, people not trusting you, because you're in the middle, is also very emotional. And I think the only way we could learn to deal with it is to say, this is part of the job. When you're in the middle, at the seam, where two pieces meet, you're always in a very vulnerable, delicate place - to acknowledge it, that you will face negative reactions from the simplest, where, well, I don't quite believe that you are doing it out of the goodness of your heart, all the way to accusations that you're doing it because you're getting money out of it, you know. It's just to say that's part of the job. (Participant)

This above observation among multicultural health brokers is not uncommon among workers who have no professional designations, such as the community health worker (CHW). Despite their positive contributions to the health system, CHWs have also experienced stressors in their work. Foremost are tensions and conflicts in power and perceptual differences between them and health professionals. For example, the traditional medical hierarchy that places status and power on health professionals has raised issues of equity and autonomy given the fact that CHWs themselves possess a

body of cultural knowledge essential to the provision of quality health care (Jackson, Brady, & Stein, 1999).

Perhaps the marginal role of the cultural broker can be explained by Geertz's (1960) view of the cultural brokers or mediators, who by nature operate at the edges of two asymmetrical relationships. There is always one who has more power than the other and most often, the cultural brokers will come from the subordinate entity. The historical evolution of cultural brokers has shown that they emerged in situations of conflict and tension as a consequence of unequal status. It should be no surprise that emergence of cultural brokers in North America was documented during the colonization period (Szasz, 1994). Thus, as marginal persons, cultural brokers/mediators must always struggle to assert his/her contributions in a helping relationship at the individual health encounter or in his/her role of ensuring that institutions respond to the unique and multiple concerns of a culturally diverse population at the system level.

As such, cultural brokers function within a context of ambiguity. Press (1969) defines ambiguity as a concept where the broker acts in "clear contextual capacity of the other culture achieving dual competence" (p.70). The multicultural health broker negotiates the boundaries between clients and service providers or between communities and institutions. The skills of dual competence in both realms are essential to a productive negotiation of outcomes that is acceptable to both entities. The multicultural health broker must have immense adaptability and flexibility to act and think according to the current cultural context. The biggest challenge is that there are no hard and fast rules and multicultural health brokers must rely on the values they hold and sometimes their good sense of how to deal with specific situations.

> And so, in it, it's about able to deal with ambiguity, able to seek a solution that is grounded in higher level of principles and values. (Participant)

To be able to cope with ambiguity and marginality while building people's capacities, the participants mentioned emotional maturity as one of the personal qualities of a multicultural health broker. One participant defined emotional maturity as "being able to transcend personal struggles and having clarity of mind grounded on values and principles so that one can focus on the work". Emotional maturity also

comes from having a critical awareness of one's own power and recognizing that this power emanates from the people you serve. The participants felt that a multicultural health broker must be aware of this power and should know how to let go of it in order to achieve the goal of building people's capacities.

Lastly, the multicultural health broker must be imbued with a sense of hopefulness that allows her/him to be creative and solution-oriented. Most of all, it is meant to be inspiring to people who are experiencing despair and hopelessness.

> I'm sure a couple of my colleagues have mentioned you have to be incredibly hopeful. I don't know, there are skills to being hopeful, in the way you solve a problem or you enter into relationship, or the way you speak. By having a hopeful orientation, you really make things happen. Always seeing possibilities where there seems like there's no way things will change. I think it's probably a set of skills that we could hone in on and help future brokers to develop. I think we're very lucky at this moment within the Co-op, most of my colleagues are incredibly hopeful people, otherwise they're not around, because the issues are so immense and it keeps the same, over and over again... And in there, is more than being kind of creative or solution-oriented, is also a very strong sense of hopefulness. I guess, almost, a sense of what might be, or kind of, a sense of beauty when things are better, that you want to work towards. So it might not happen in one family's case, but over time you hope that will lead to some, some, what's really literally, a beautiful place to be at for the families or for us. So it's to be very hopeful and how to work in that way. (Participant)

VII. The Multicultural Health Brokers Co-operative: Struggling for equity in an unequal society

This section introduces the Multicultural Health Brokers Co-operative and its role in promoting and nurturing the multicultural health brokering practice. In the study, the participants were asked about what they perceived to be the role of the Co-op in supporting the multicultural health brokering practice and the multicultural health brokers, the benefits they have gained as members of a formal organization and the challenges that the Co-op faces. This section will integrate into the discussion literature on co-operatives, particularly workers' co-operatives. The challenges to the MCHB Co-op will be discussed using these factors to define the issues.

The role of the Multicultural Health Brokers Co-operative

The Multicultural Health Brokers (MCHB) Co-operative was organized to respond to a growing demand for multicultural health brokering services in immigrant

and refugee communities. In 1998, the multicultural health brokers were invited to be part of the health care system as employees. The multicultural health brokers realized that the nature of their practice required them to work with their communities as well as with institutions – two entities that are not always in congruence with each other. They were also aware that these two entities are unequal, and those with less power, the ethnic minority communities, needed advocates to leverage support for them. If the multicultural health brokers were to be part of the health care system as employees, they feared that a large institution with a corporate structure and less flexibility might limit their ability to advocate for their clients and communities. So the multicultural health brokers decided to form their own organization. One participant recalled:

> We wanted to be in the community. To some degree, not being, operating out of the system or the institutions or operating even for a while out of a formal office had given us some very strong symbolic value about autonomy and being with the people. (Participant)

The need to be in the community so that they ccould be advocates for them was the primary reason for opting not to become institutionalized within the formal health care system. In choosing which form of organization the multicultural health brokers would adopt, they considered several factors: the first was their commitment to democratic and collective processes that allow for diversity and inclusiveness. The multicultural health brokers chose a co-operative structure because of its egalitarian and democratic foundations.

> ... because this is a members-owned, members-operated organization, I'm praying that we will never become what other organizations have become, even very, very grassroot organizations, because they chose a different corporate structure where there is a board, there's the executive director, and then the workers, and then the people in the community. Whether it's a public institution or it's a non-profit organization, the danger is it becomes a hierarchical entity where the board is removed from the realities of the people and yet they're making policies, deciding what should happen, right. And you, we see this all the time, where frontline workers are feeling very frustrated because the policies that are made, don't reflect the day-to-day reality and they have very little say over how policy is developed. So, I'm hoping, by consciously choosing to become a worker's cooperative that is flat, where it's democratically all owners and operators and also employees, then we don't have this hierarchy. We are it. All we need to do is stay grounded in people's struggles and their desires and their hopes, right. So it eliminates many of the potential levels of being removed or being, being irrelevant. And so, the structure itself I hope will support our work so we're always, always grounded in the circumstances of the people. And so, the three fundamental unique elements of the co-op, I hope will help us: the democratic governance, the accountability to the people rather than the system, which means there will come a time when we might have to choose to

> let go of certain funding, because it doesn't meet the true need of the people. I hope we'll be decent enough to say, remember, we promised that we're accountable to the people, then therefore we would be willing to let go. (Participant)

The second reason for choosing a co-operative structure was the search for an organization whose philosophy resonates with ideals of equity and social justice. The multicultural health brokers had worked long enough in their communities and were aware of the struggles of ethnic minorities in overcoming barriers to social mobility and advancement.

> But then the final principle is about, rooted in social objectives of justice and equity. And so all those three things, hopefully will help us, over time, to stay very relevant, to stay committed to issues of social justice, and to stay always as a small struggling example of democracy within the context of diversity. (Participant)

Co-operatives are organizations that sustain themselves through organizing collective work for a common good. The history of co-operatives is nurtured by the ideals of social emancipation and democracy. From the early 1800's to the present, Fairbarns et al (1990) succinctly summarized the development of co-operatives from a vantage of social and cultural ties that bind memberships together and render the co-operative economically viable. These ties are founded on purely economic interests, but are deepened by a "shared experience of separateness or discrimination in society, cultural or political awareness" (Fairbarns, Axworthy, Fulton, Hammond, & Laycock, 1990 , p.75). In other words, co-operatives have emerged as a response to social and economic inequities experienced by certain groups in society. The first co-operative, at the turn of the 19th century, was a response to the poor working conditions and poverty of factory workers in the newly industrialized England. Fairbarns (1990) also notes that a primary motivation in forming co-operatives has been the political and cultural goals of "solidifying a minority culture or nationality" (p.73).

Co-operatives began to challenge the dominance of capital in economic endeavours at the time of movements for democratization of society during the mid-18th century. Co-operatives were avenues for the disempowered British working class to gain some control over economic resources and to institute egalitarian forms of distributing power (Fairbarns et al., 1990) (Oakeshott, 1978).(Quarter, 1992)

In Canada, the development of cooperatives has been more active in the agricultural sector, as opposed to the British experience in urban industrialized areas. This can be attributed to the lower concentration of urban labour and less polarized social and economic opportunities (Fairbarns et al., 1990). Nevertheless, the growth of farmers' co-operatives was a reaction to the dominance of the economic and political elite in central Canada, who were developing policies that impacted rural Canada. The rural sector, represented by farmers across the prairie provinces, desired greater economic and political participation in the country's agricultural development. Agricultural co-operatives were and still are the largest co-operative network in Canada; they earn billions of dollars and have considerable influence in policy making in the agriculture sector (Quarter, 1992).

There are also many forms of small- and medium-sized co-operatives engaged in a wide range of entrepreneurial as well as social development ventures. Examples of these are consumer or user co-operatives, credit unions and workers' co-operatives. These co-operatives form what Quarters (1992) calls the social economy – economic enterprises that are independent of the government, fulfill social objectives and are "socially owned". The concept of social ownership means that members of the co-operatives are owners of their own enterprises. But more than staking a claim to property, social ownership is associated with decentralized and participatory decision-making, greater public accountability and progressive democratization in the workplace (Quarter, 1992).

A workers' co-operative, although one of the least common types of co-operative, is the embodiment of social ownership principles. The workers own the enterprise for which they work. Oakeshott (1978) cites three important features of a workers' co-operative:

- Those who work for the enterprise are not making profits for anyone but themselves;
- The workforce has no external masters; and
- There is a more or less democratic regime – one person has one vote.

These features articulate basic principles of equity for wealth distribution and democratization in the workplace environment. Quarter (1992) reported that in 1989

there were about 300 workers' co-ops in Canada, generating revenues of $233 million for 6,140 members.

Employment is a responsibility of a worker's co-operative. The MCHB Co-op must continuously generate employment for its members. In the MCHB Co-op, all members are also contracted workers which means that every member works in a certain project and is remunerated for the work that he or she does.

In the study, when the participants were asked about the role of the Co-op in supporting the multicultural health brokering practice, there was a consensus among the participants that its crucial role is in the promotion of the practice, not only in the health care system but also in the social services sector. This role involves consistently doing good work in the community and collaborating effectively with service providers.

> So to some degree, to gain the trust of other agencies and other groups is to genuinely be there for the sake of making a difference, not for the sake of esteem or, you know, building an empire. That's hard, because we're just a beginning organization. We do want to have recognition, but it's a delicate fine line that we walk. Yes, we want rightful recognition. But sometimes, to gain the recognition we ultimately want, is to be very giving, to be there, sacrifice our time and our energy for other organization, for other groups, without always being mentioned, oh the brokers were, you know, the partner. Because we, I hope we know that the kind of long-term support we need is not gained by, sort of glitzy, here we are, we're helping you, because people will know that we're doing it, again, out of self-interest. What we really genuinely need to do is to, to be truly of service to others, sacrifice sometimes our time, and give help without asking for anything in return. (Participant)

Within the organization, the participants saw the MCHB Co-op as focusing on defining the multicultural health brokering practice and translating this definition into a set of standards to guide the multicultural health brokers in providing consistent and quality service.

> I hope that in the future, we have a set of standards. This is the most priority I think, also boundaries. I know that in some agencies, they do have a contract with their families for a certain period of time, like we want you to do this, and I think that it's quite good, because the family will know that they have to be responsible for it, everyone has to contribute to make changes. (Participants)

> If there's a way of measuring as how my work is being done, am I doing all there is to be done, what is it that I need to do different or more of to accomplish, so all these...reflecting back and looking at you know, am I doing the right things at the right time, and if not, would there be somebody to come to me and is willing to learn and change directions on my part, as how much as I can achieve on my part still remains to be seen. (Participant)

The grounded theory on multicultural health practice offers a starting point for developing this set of standards. The theory explains what happens in multicultural health brokering through the four stages of initiation, building connectedness, brokering support and achieving equity of access to health. The four dimensions of one-on-one support, building supportive groups, building a community's capacity and catalyzing institutional change identify arenas of work where multicultural health brokers can assess their skills and interests. The theory provides the avenue by which questions, issues and concerns about the practice such as issues of confidentiality, boundaries (the dual role of MCHB and a community member), the difference between counselling and giving advice etc. can be meaningfully discussed and resolved. The discussion could then lead to the formulation of a code of ethical conduct for the multicultural health brokering practice.

Participants' perception of support from the Co-op, and membership benefits

When asked what support the Co-op has provided to the members, all the participants mentioned that employment is the foremost. Since the MCHB Co-op was organized in 1998, the multicultural health brokers felt that the organization had provided them with financial support through continuing employment opportunities.

Participants also felt that the Co-op offered emotional support to its members in ways that are more personal than what they said they would experience in other organizations. The participants value the warmth and trust among colleagues, especially during difficult moments of working through a complex case. Only one member said that she felt isolated and lonely and did not explain the reason why.

> We need informational and emotional support. We walk through cases or situations together and talk about it so that if you are doing something right or wrong, then that's what you thought you should be doing. For me, it's a time that I say okay, I need to do this now, I can think here and do my thing... I am glad that help is there. (Participant)

> I know that there is a lot of support there if I need it, you know, that makes a person feel good, that you're not alone, that there are others as well. (Participant)

In relation to feeling supported by colleagues, most of the participants said that being a member of the Co-op had increased their confidence and self-respect. From their experience since the Co-op was organized, the participant felt valued by colleagues

from other agencies; their credibility had increased and they felt respected even by health professionals.

> I guess I feel that I have gained credibility in the community and the health profession. Yes, being a member of an organization and also being an agent of change. That in itself builds credibility. Doing presentations and talking to people doing research. (Participant)

> I think that as soon as we developed the co-op, people started to value us, started to recognize us, and treat us with more respect, it's not just like a cultural translator, they realize that we are more than just interpreters. (Participant)

> I think all of us, around the table, were more very individual, not view ourselves as a co-op, but now, we start to develop more professional talk, professional discussions, and all of us are more open to talk, so there's a lot of change. (Participant)

> I think it changed for everybody; it changed for everybody and for all of us. I think that it was great because before, we didn't know who we were, we knew that there was something there, but if I had to give you a name for that, it's so much that it's not made for it. I think that it's great that we have a co-operative today, we could come up with something else, but we came up with the co-operative idea, I think it's important to have a co-operative organization. (Participant)

Other benefits mentioned by the participants included training opportunities, access to technical information and introduction to a network of service agencies. The training opportunities that increased knowledge and skills were benefits that the participants appreciated as being part of an organization. Many of them said that they have gained knowledge about the technical aspect of their work, but more importantly they have learned about resources that they could access for their clients and communities. These benefits will undoubtedly rebound to the clients' benefit.

All the participants agreed that the organization of the Co-op has improved their work immensely and contributed to their personal growth. Many of them felt that the Co-op had increased their confidence and credibility to deal with other organizations.

> Feeling that you are very formal, established, makes you very strong by yourself that you are belonging to something and even the working with the other member of the Co-op. I feel very confident, that I am belonging, all this people are working from the same background, from the same intention. (Participant)

Challenges to the Multicultural Health Broker's Co-operative

Although there are many fine examples of successful workers' co-operatives around the world, many of those who studied co-operatives maintain that workers' co-operatives are the most difficult to sustain. (Oakeshott, 1978; Quarter, 1992). Workers'

co-operatives are the least sustainable of all types of co-op because of three reasons: financing is the co-op's major problem owing to its low capital that comes from the limited funds of the workers themselves, the enterprises tend to be labour intensive, democratic governance requires a large time commitment that is difficult to sustain over time, and lack of managerial skills among the workers (Quarter, 1992). The challenges to the MCHB Co-op resonate with Quarter's observations and will discussed in this section.

Financial sustainability

The participants' main concern for the MCHB Co-op is the sustainability of their funding sources. This threatens their employment security, and more importantly their ability to provide sustained programs and services to their communities. The MCHB Co-op's financing comes from service contracts that they have negotiated primarily from the local health authorities and social development funding agencies. These service contracts are mostly short-term, covering a period of one to two years. Every year, the Co-op has to develop and negotiate proposals to seek funding for services to ethnic minority clients and communities. Sustainability of the organization is the Co-op's major strategic issue. As the multicultural health brokering practice increases its reach to the community, there will greater demand for services and yet government support has not been consistent. The MCHBs' primary investment in the Co-op is their talent and skills rather than monetary capital. The public service sector, particularly the health and social services, does not have a clear and solid policy on equity and diversity that could translate into resource allocation priorities to support interventions such as multicultural health brokering on a sustainable basis. Financing of the MCHB Co-op depends primarily on public sources that are vulnerable to changes in the political and economic environment.

> We don't have a permanent contract, we have contracts every year, but it's renewable, so after this contract is finished, Capital Health can actually say that next year we don't need their services anymore, so we don't have a permanent contract. (Participant)

Fostering democratic governance

Democratic governance requires a large time commitment, which is difficult to sustain over a long period of time. Practicing true democracy means equipping members with tools of participation, fostering commitment to participate and creating

relationships that support participation (Hennestad, 2000).

> Sometimes we need to make decisions as we are working now, sometimes maybe lack of understanding of the English language, things get twisted or not understood, and like this happened, because when I had to give an example, 'Gee that's not what I said, that's not what I meant' and I was right because the multicultural health broker that was sitting beside me, she looked at me, and then I said, 'That's not what I said' and she said 'Right', so that just comes up. What I'm saying is I don't know if we're all at the same level there, of understanding, of making decisions. (Participant)

> We have democratic governance in the Co-op and we do decide things together. We need to learn more about decision-making. (Participant)

Because of the intensity of their work, it is always difficult to find adequate time for organizational activities. Time is an important resource inherent in the practice. Multicultural health brokers almost operate on a 24-hour work schedule. Since they are known more as members of their own community, they make themselves available anytime.

> I wish that all of us would have a full-time job, and then all of us could quit another job, because if you work full-time here and part-time there, I don't know how much you could concentrate in doing the work. (Participant)

> Too many meetings... long meetings... (Participant)

The multicultural health brokers also come from cultures where the concept of participation is not necessarily synonymous with western-style democracy. The challenge is not because the Co-op members have no desire to participate, but to create participatory processes that are congruent with their cultural experience. For example, group discussions may not always be the best forum for inclusive and collective decision-making. Sometimes the effective strategy to generate genuine sentiments could be obtained with one-on-one individual or written responses. Creating democratic participation within the context of diversity requires an appreciation and understanding of the varying communication styles of different cultures. Language is the most obvious of these differences. Most often when the discussions involved sensitive issues or complex topics, some of the MCHBs were not able to articulate what they really wanted to say because of the difficulty in expressing their views in English. Other areas of cultural differences involve the ability to accept feedback openly, disclosure of personal feelings and interpreting cues and gestures accurately.

The MCHB Co-op must be vigilant in sustaining egalitarian relationships in the organization and must avoid the pitfalls of bureaucratization that most often follows a growing organization. The constant challenge is remaining true to the most essential foundation of co-operatives and democratic governance – the belief that power resides within the members.

Building organizational capacities

When the MCHB Co-op was born, the members relied heavily on their own knowledge, talents and experience in organizing the Co-op, with the assistance from a co-operative consultant. The initial organizing effort was successful, as we now know. The MCHB Co-op is now fully operational and viable. However, an organization must constantly adapt to the dynamics of the external environment for it to maintain its relevance to the larger society that it serves. This includes ethnic minority communities, health institutions, social service organizations and funding agencies. These external players will have higher expectations once a group becomes formally organized and visible. More and better services will be among those expectations. These are external pressures that the MCHB Co-op must respond to progressively. It means new ways of structuring organizational work, enhancing existing skills, developing new competencies and building internal leadership and managerial skills. These are overwhelming tasks for an organization that has just gotten off the ground and has limited resources to invest in intensive organizational work.

Blending entrepreneurial and social objectives

Finally, the MCHB Co-op must always face the challenge of blending the entrepreneurial objectives of providing employment security and addressing the social objectives of equity of access to health by ethnic minorities. The task of this dual commitment is daunting, and most often the two objectives are not always congruent. The reality of the MCHB practice demands that the multicultural health brokers be sensitive and conscientious in unraveling health issues and all their dimensions, and that they explore holistically all paths to the desired outcomes. This means that responsive interventions can include venues other than the health sector such as mediating between family members, connecting women to community supports, organizing small groups for practical needs, emotional support etc. Unfortunately, these

forms of support are not always regarded as having economic value and thus are not translated into remuneration for the MCHBs. In other words, most of this is largely unpaid work that comes from the MCHBs' personal commitment to the clients and is perpetuated by a fragmented and specialized public service system that narrowly defines its services within the strict confines of institutional mandates and/or professional standards. Yet these informal supports within the context of ethnic minorities and other marginalized populations are most critical in promoting and sustaining the health of these individuals and families. Thus, the MCHB Co-op most often absorbs the cost of unpaid work in providing direct service which should have been supported by public service institutions. This impacts the Co-op through the reallocation of equally important administrative resources to direct services. As a business enterprise, it does not leave the Co-op much room to invest in project development activities, which it needs to sustain the organization in the long term.

> It's a reality of the co-op and it's also a reality each member has to deal with. Because it is a worker's co-operative, we're in it to generate employment for ourselves. There's a great deal of irony in that because there is misfortune in the community, that we have found work.... we often don't all have full-time work and we're working full-time but with limited pay, still we're getting work because of the family's misfortune. And so, there's this delicate balance, that, on one hand is, there's some degree of self interest, it's generating employment for us, and yet on the other hand, it's also remembered this is an organization about social justice, right. It exists for social objective. It exists as a democratic organization where we're not just here to get a job. We're here to build an organization that is decent and it's here for a greater set of purpose than just get funding and keep going, right. It's a struggle that I don't know if we're always conscious of, but it's there all the time. It's ever-present. It's the very nature of a worker's co-operative. You're always torn between the entrepreneurialship of being a member who's a worker, or an organization that generates employment out of a situation of social injustice. And so there is the entrepreneurial piece of it and yet there is the social objective. How to stay in the middle, right? It comes up when, when, we have a certain new set of funding and people's sense of, here each of us is challenged to not just think about, okay, I gotta get a few hours out of this funding because I'm a member, I deserve it, versus, okay I will think about what is best for the group... but it... actually poses a difficulty for us too, because when we, as we start to work as a co-operative, introducing a practice, even though not new, but not very known, we were struggling with introducing two new concepts to others: health brokering but also as a workers' co-op. Some felt that not knowing what cooperatives are thought maybe we were a form of privatization. Others thought, you know, literally, someone said are you like a communist organization. (Participation)

In a study of collective decision-making in a large organization, the above-mentioned problems can lead to degeneration of the co-operative and reversion to the

traditional structures of hierarchical organizations, especially if the organization has been taken over by private business organizations (Cornforth, Thomas, Lewis, & Spear, 1988). However, another study revealed that the survival rate of workers' cooperatives has been good and that worker participation has increased over time (Cornforth et al., 1988). Quarter (1992) supports this by citing successful workers' co-operatives in micro-businesses. The successful worker co-operatives in their study are those where types of jobs done are by members who have similar skills, and where there is a community-based system with support infrastructure for finance and entrepreneurship. In the experience of the MCHB Co-op, all the members have similar skills as multicultural health brokers. There is a continuing and progressive demand for their services in the community as shown by the growing number of clients who have accessed their services.

Finally, Cornforth (1992) reiterates that the "degeneration of a workers' cooperative occurs most clearly when it departs from cooperative principles and thus ceases to be truly cooperative" (p.120). These principles are open membership and democratic control by members on an equal basis. He proposes safeguards against degeneration that a workers' co-op should adopt. These include: meaningful control over decisions on investment, resource allocation, wage, product/service, technology and workers' control over aspects of jobs such as conditions of employment, supervision and discipline, work organization and job content. These safeguards will be important in identifying organizational factors influencing the viability of the MCHB Co-op as an economic enterprise to support the MCHBs, and as a vehicle for advocating equity and social justice for ethnic minorities.

VIII. Contributions of grounded theory to the multicultural health brokering practice from the literature

In grounded theory studies, the role of the literature is dynamic and changes throughout the theory construction (Glaser, 1978; Schreiber, 2001). At the beginning, the literature provides a background in the area of study to allow focus and direction in the proposed investigation. During the study, the literature is a source of data that can be compared with emerging categories. Towards the end of the study, the literature is a

nesting place where the product of the grounded theory can find a home. Glaser (1978) recommends, "when the theory has been sufficiently grounded and well-developed, then we review the literature in the field and relate the theory to it" (p.31). The search for literature at this stage of the study is not to find proof for the theory but to look for literature where the resulting grounded theory can be related to through citation.

The search for related concepts to the grounded theory of multicultural health brokering practice in literature points to areas for enriching existing theories or areas where there are gaps in current knowledge. In particular, it includes continuing work on "densifying" (Jesewski, 1989) or enriching the cultural brokering theory, adding a cultural dimension to social support theory, integrating a cultural perspective in social work practice, enriching community development practices, supporting health promotion and strengthening participatory and collaborative research. These are relevant areas where multicultural health brokering theory can make a useful contribution.

The role of cultural brokering has been studied in nursing practice and elaborated how it can improve nursing care (Jezewski, 1993; Jezewski, 1994; Jezewski, 1995; Morris et al., 1999; Sharma, 1988; Tripp-Reimer & Brink, 1985). Hence, this study chose to present the contributions of the multicultural health brokering practice in primary health care.

Broadening the cultural brokering theory

The grounded theory of the multicultural health brokering practice extends the cultural brokering theory first developed by Jezewski (1989). Jezewski's (1989) cultural brokering theory explains what happens in a health care setting when immigrant patients are unable to access health care. Cultural brokering explains patient-provider interaction in a health encounter where there is a breakdown in communication. Subsequent studies by Jezewski (1995) in different settings such as intensive care units (ICU) and homeless shelters sought to further enrich the theory. In all these studies, the nurse was the cultural broker and the nursing practice is the arena in which cultural brokering could be useful. The grounded theory of multicultural health brokering theory developed in the current study extends Jezewski's explanation into a wider locus

of tension and conflict: that of ethnic minority communities and the formal system represented mostly by health and social service institutions. It also captures the cultural brokering process in a variety of settings where the theory can be used in a group, in the community and institutions. These varied settings are also sites of health encounters that occur in a continuum of health promotion, disease prevention, acute care and rehabilitation where the theory could be useful when dealing with complex health issues involving people from diverse cultural backgrounds. The grounded theory on multicultural health brokering theory presents cultural brokering from the perspective of non-professionals as cultural brokers. This is a useful framework to guide those who work with people and communities from diverse backgrounds in non-clinical settings and the broader areas of the social service sector.

Enriching social support theory

The grounded theory on multicultural health brokering is closely linked to the social support theory, which is also a relatively new theory that appeared in the literature in the mid-1970s. Hupcey (1998) noted that so much has been written about social support that that the term has come to encompass a variety of conceptualizations. Social support is a multi-faceted concept that challenges the task of arriving at a single definition. Current definitions of the social support theory revolve around its five basic features: type of support provided, recipients' perception of support, intentions of provider support, reciprocity and social networks (Hupcey, 1998). Social support is viewed as the type of resources provided by other persons (Cohen, Mermelstein, Karmarck, & Hoberman, 1985) in the form of emotional support such as caring, a sense of being valued and loved or being a sense of belonging. The second feature of social support describes it as the extent to which the recipient believes that the social support has fulfilled his/her needs (Procidano & Heller, 1983). Shumaker and Brownell (1984) referred to the perception of providers of social support that it (social support) enhances the well-being of the recipient. The fourth feature describes social support as the exchange of resources between the provider and the recipient (Antonucci & Jackson. J.S., 1990). The last feature involves the support that is "available or accessible to a person through social ties to other people, groups and the community" (Lin, 1979). The

literature on social support is extensive and the study included only references that were relevant to the multicultural health brokering theory.

The multicultural health brokering theory can deepen current concepts of social support by integrating a cultural context to the theory. For example, Ell (1996) examined various research studies on the role of social support in coping with serious illness. Her examination raised several problematic issues and research questions about the social support theory. These issues included: understanding the broader environmental context of providing support, the role of culture in providing family support, and the role of non-professional interventions in providing support. The grounded theory of multicultural health brokering offers a framework by which these questions and issues can be clarified. For example, the holistic approach embodied in the multicultural health brokering practice establishes the social context of individuals and families seeking social support. The cultural approach towards framing the context of ethnic minority families speaks of broad environmental contexts such as pre-migration experience, immigration experience, adaptational difficulties, family structure and relationships including gender roles and concept of the self. These layers or frames of reference offer a rich knowledge of how individuals and families perceive and understand their situation and what they think would be strategies or interventions to support them. This knowledge embodies a cultural explanation of their situation that may impact the nature of the social support that they may need.

The role of non-professionals in providing social support is another contribution that multicultural health brokering can help to understand including the difference brokers can make in achieving positive health outcomes. The helper therapy principle developed by Riesmann (1990) (as cited by Roman et al., 1999) calls attention to the growth that non-professional helpers experience when they provide support to people who share similar characteristics and similar issues with them. In the multicultural health brokering practice described in this study, the MCHBs were most happy and fulfilled when working with their clients. This positive feeling brings a sense of hopefulness into the helping relationship is a good augury for accomplishing the goals of the intervention.

Social support as a critical factor for buffering stress (Cobb, 1976) has been cited in the literature, particularly if this is delivered by people who are considered "peers" by recipients of social support. Hurdle (2001) summarized literature on the role of social support in women's health and health promotion and showed that women coped well with illness, adopted preventive health behaviours and practiced health-promoting behaviours when the providers of social support were also women. This is also especially true with immigrant women who are generally at risk because of the dramatic shift in their roles and lives when they moved to the new country, and hence the need to connect with other women for stress reduction (MacKinnon & Howard, 2000). The theory of multicultural health practice where building connectedness is one of the stages in the theory offers a conceptual framework on how to mobilize social support within the context of social isolation and stressful life events such as migration.

Integrating a cultural perspective to social work practice

Social work practices and multicultural health brokering have fundamental similarities in their areas of concern - that of the vulnerable, oppressed and isolated who live in poverty and who seek social justice. Because of this shared mission, the multicultural health brokering practice is potentially a theory that could enhance the social work practice. Multicultural health brokering theory espouses a practice that is founded on a holistic, relationship-centred and strengths-based approach. Jacobson ((2001) contended that the current social work practice is eviating from its original mission. She explained why:

> Today's social work students are trained more often as clinical practitioners rather than advocates for social change. In most service agencies, social workers focus in the individual problems of their clients rather than larger, systemic issues, and the working relationships are generally power imbalanced. The social worker-client relationship more often resembles that of a therapist and patient than that of two people united in the struggle for greater personal and social good... Social work's emphasis on therapy has become so substantial; in fact that many of the activities long associated with the profession (such as system reform work, community organizing, advocacy, social activism, community economic development and human capital development) are no longer called "social work". Furthermore, when social workers do undertake these activities, they often imbue them with a therapeutic quality or an emphasis in individual behavior. They do so because the therapeutic modality predominates in social work. (Jacobson, 2001 p. 3)

At the level of providing individual care and support, Jacobson (2001) argued for re-orienting the "helping profession" that would change the relationship of the social workers and the people they serve. The re-orientation process implies restoring the original role of the social worker from a clinician to an agent of social change. Jacobson (2001) identified the potential roles of the social worker as a result of the re-orientation process: coach, staff, network, resource developer, **broker** (emphasis mine), policy advocate and personal consultant. In these roles, the helping relationship is transformed from a therapeutic relationship into a reciprocal relationship. Reciprocal relationships are characterized by a recognition of the power imbalance and the conscious effort of the social worker to build egalitarian relationships.

The theory of the practice of multicultural health brokering can provide a framework for social workers to develop a relationship-based practice that is reciprocal and empowering. The theory views the individuals not merely from the issues they present but also the totality of circumstances and conditions that brought them into their present situation. To be able to arrive at this, multicultural health brokering creates opportunities for valuing people's strengths and capacities and building trusting relationships. The four stages of multicultural health brokering (initiation, building connectedness, brokering support and achieving equity of access to health) can guide the social work practice in moving their clients from a problematic situation to a place where the clients are able to seek solutions by themselves. The four dimensions of the multicultural health brokering practice offer progressive options for the social worker to increase the clients' capacities at the level of individual and social functioning within the group and the community. Furthermore, multicultural health brokering theory can provide a systematic process of integrating a cultural perspective into the social work practice. Cowger (1999) referred to this as the "indigenization" of social work, which means a deliberate attempt to ground social work practices in the everyday life of the practitioners and the client in cross-cultural settings rather than relying on practice standards that have been developed within the context of western cultures.

Beyond the individual, Jacobson (2001) also suggested the reconceptualization of personal problems and individual issues. This exemplifies a re-framing of personal struggles as ultimately connected and collectively has implications to societal issues.

The dimensions of multicultural health brokering also simulate the multi-faceted practice of social work. *The dimensions of helping individuals, enabling groups and* communities to experience change and working for systemic changes are viewed as inseparable and interrelated. The most compelling congruence between multicultural health brokering and social work is that both practices serve groups of the population who have been disenfranchised and disempowered. To be able to address external forces that create problems for individuals and the community, perhaps social workers and multicultural health brokers must work together to achieve desired positive outcomes and more importantly to create lasting social change.

Strengthening community development practice

Much of the literature on multicultural organizing emphasized how organizers can develop cultural competence when working with ethnically diverse communities (Gutierrezm & Lewis, 1998). The multicultural health brokering theory can broaden community development practices by adding to its knowledge base a framework for culturally competent communities organizing ethnic minority communities. The theory provides a process by which indigenous practices of creating collectiveness and building communities may be blended with western ways of mobilizing communities. In the multicultural health brokers' experience, beliefs about leadership, building group relationships and decision-making are culturally embedded. These traditions are brought to the new country by immigrants and most often render western ways of group development ineffective and unworkable. The properties within the stages and dimensions of the theory can inform the community-organizing literature on respecting and valuing cultural norms of leadership and the decision-making processes. The theory also offers ways by which community development can become culturally responsive and appropriate. It suggests a process of understanding how people from different cultures seek connectedness, how they build and share a sense of togetherness and how they resolve issues collectively. For example, when working with communities of colour, who the community organizer is is as important as the purpose of the community organizing (Rivera & Erlich, 1995). The multicultural health brokering theory identifies the appropriate qualities of a multicultural health broker. One of these

qualities is the shared experience and cultural backgrounds of the MCHB that contributes to her/his effectiveness in achieving desired outcomes. In community-organizing work, this is important to establish a level of trust between the organizer and the community and more importantly to be able apply a cultural lens or vision that allows the organizer to see the issues from the perspective of the community.

Supporting health promotion

Health promotion is defined as a "process of enabling people to increase control over and to improve their own health" (World Health Organization,1986). This definition embodies the twin pillars of empowerment and community participation (Labonte, 1993). Labonte (1993) presents a powerful framework that integrates these two foundational principles of health promotion. His basic premise is that there is no single path to an empowering health promotion practices. Labonte (1993) appropriately named this framework the "Empowerment Holosphere". In this framework, there are five spheres of empowerment (Labonte, 1993). At the individual level, the delivery of care is offered in a supportive, non-threatening way that respects and acknowledges a person's capacity to make decisions for his/her own care given the necessary support and opportunities (Personal Care). People who have similar issues and who share common interests for self-betterment are in the second sphere of empowerment, where opportunities are created to bring people together and to achieve a level of connectedness that could begin the process of change (Group Development). The third stage of empowerment involves bringing people together to discuss individual issues that have socio-political policy implications (Community Organization). This stage is concerned with creating equitable power relations among community groups and institutions so that communities who are marginalized begin to develop the confidence to aspire for change. The fourth sphere is described as "advocacy with" in supporting groups in expressing their voices – a crucial step towards achieving real empowerment (Coalition Building). The last sphere involves a broad-based process of change; working in solidarity with other groups and organizations along societal issues (Political Action). These five spheres of empowerment intersect with each other and no one person could possess the skills and time to work in all of them.

In the empowerment holosphere, genuine and lasting change that supports and sustains the promotion of health involves multi-level strategies and action demonstrating the five spheres. The grounded theory of multicultural health brokering practice is founded on the inevitability of addressing societal issues impacting the health of the people and community. The four dimensions of multicultural health brokering, namely providing one-on-one support, building supportive groups, building community capacities and catalyzing institutional change all recognize that even the personal problems of individual clients have policy and system implications. Labonte (1998) calls this "making private troubles public issues" (p.95) to emphasize the importance of viewing individual problems within the context of systemic factors. The four dimensions of the multicultural health brokering practice parallel Labonte's (1993) empowerment holosphere except the last two spheres - coalition building and political action.

Strengthening collaborative and participatory action research

This study demonstrated the blending of participatory action research (PAR) and grounded theory. The simultaneous process of data collection and analysis inherent in the PAR process (Hall, 1992) is also congruent with the constant comparison method in grounded theory wherein data collection is an ongoing process with data analysis (Glaser, 1978). Grounded theorists such as Glaser and Straus (1967) and Wuest (1995) have encouraged collaborative analysis between the researcher and research participants in the development of the theory.

In the study, the collaborative process was most evident in the theory construction stage where the participants were intimately involved with coding their data, exploring themes, analyzing the categories and conceptualizing the relationships of categories. The step-by step collaborative process designed and implemented in this study could be applied to future research using grounded theory with a participatory research orientation. In addition, the participative theory-building process offers insights on conducting the process within the context of diversity and inclusiveness. For example, sharing of power control in the research was crucial for creating a sense of ownership of the research and sustained the MCHB participation throughout. The

formulation of ethical principles early on in the research process helped to anticipate potential conflict in the relationship between researcher and participants. Designing simple and practical tools that would address linguistic and cultural barriers to participation was helpful in accomplishing the goal of collaborative analysis and theory construction.

In summary, the five areas (cultural brokering, social support, social work, community development and health promotion) where the grounded theory of the multicultural health brokering practice can make a contribution to the literature are relevant in promoting ethnic minority health. Multicultural health brokering practice can offer a framework for demonstrating culturally competent practices in health care and the social services sector. These sectors are mainly responsible for addressing the needs of vulnerable and marginalized groups and potentially the arena where multicultural brokering practices can be used to harness inherent talents and untapped capacities. Finally, this study envisioned a valuable contribution to the practice of collaborative and participatory action research by offering the steps of collaborative analysis used in the research.

IX. Testing the credibility of grounded theory on the multicultural health brokering practice

What makes a good grounded theory? Glaser (1978) contends that the power of the theory lies in its credibility, particularly in the concepts embedded in the theory.

> Credibility of the theory should be won by its integration, relevance and workability, not by illustrations, as if it were proof... the theory is an integrated set of hypotheses, not of findings. (Glaser, 1978, p.134)

There are three essential elements of a credible grounded theory. A grounded theory must have "fit, work and grab" (Glaser, 1978) to meet the requirements of scientific rigor. This section will examine the credibility of grounded theory on multicultural health brokering using these criteria.

Criterion 1: Does the multicultural health brokering "fit" with the data generated by the participants?

"Fit" refers to the internal consistency of the theory or how the concepts of the theory relate coherently with each other to produce a unified statement about a phenomenon. Theory construction must show how concepts were conceived from the empirical data. This means that the concepts emerged from the data through an analytical process prescribed in the grounded theory method, i.e. constant comparison. Categories and properties of multicultural health brokering were derived from participants' data through a multi-level coding process. Constant comparison of categories revealed similarities and variations in the data. For example, isolation as the initiating circumstance for the need for multicultural health brokering was consistent throughout the interviews. Most of the properties of the different stages in multicultural health brokering were similarities found in the data that reached saturation. The variations in the data were found in the dimensions category particularly Dimensions 3 (building a community's capacity for self-determination) and Dimension 4 (catalyzing institutional change). The data showed that not all of the MCHBs experienced working with communities at the level of capacity building and only a few of the MCHBs were working within the area of institutional change. In the case of Dimension 3, this can be explained by differences in the level of development and maturity among communities: some communities may not be ready to tackle community issues while some may be experiencing urgent issues that needed concerted attention. As for Dimension 4, some MCHBs are in located within institutions that allow opportunities to advocate for cultural responsiveness in service delivery. Furthermore, only a few of the MCHBs possess certain skills to undertake policy development work or organizational change. The question asked among the MCHBs during the second focus group (category development) was whether the theory should include the experience of a few MCHBs. The consensus among the participants was to include both Dimensions 3 and 4 because they felt that the two dimensions were relevant and necessary in describing the multidimensionality of the practice. In the participants' view, working with communities and institutions is inevitably part of the MCHB practice.

The relationships found among the categories were consistent with two of Glaser's 16 Coding Families [Stages and Dimensions Families]. These Coding Families represent types of theoretical abstractions showing patterns and relationships that make up a conceptual formulation that will be the basis of a theory. The literature (Jezewski, 1990; Sharma, 1988; Wolfe-Gordon Consulting, 1998) was also surveyed to capture differences as well as congruence amongst categories. The variations of the categories between this study and the literature revealed the influence of context, setting and actors in the processes or actions happening within cultural brokering. For example, while breakdown in communication was the initiating property in Jezewski's (1990) study, isolation was the initiating property in this study. This could be explained by the differences between the setting and context of the studies. Jezewski's study was in a migrant health clinic while this study had multiple settings - in the community, clinics and institutions. Similarly, the literature also contributed categories that added depth to the conceptualization of the theory on multicultural health brokering. For example, advocacy was a category in the literature that also emerged in the study perhaps because both studies explored cultural brokering to address issues among immigrants.

Criterion # 2: Does the grounded theory "work" to explain what happens in the multicultural health brokering practice?

The grounded theory must "work" to explain what happened, predict what will happen and interpret what is happening in the substantive area of inquiry (Glaser, 1978). The strength of the grounded theory is its explanatory power, "the evocative construction that illuminates and explains the actions and interactions of participants as they manage the basic social problem" (Milleken & Schreiber, 2001, p.188). The grounded theory on multicultural health brokering practice provides a coherent framework that shows a sequential and logical progression of processes. This progression is the theory's predictive element, and illustrates how a practice is initiated and carried through to resolution. The theory delineates dimensions or conceptual elements rendering breadth to its explanatory power. The four dimensions of providing one-on-one support, building supportive groups, building a community's capacity and catalyzing institutional change provide the contextual settings where the theory can guide practitioners in understanding social interaction, particularly in situations of

tension and conflict that occur in these settings. For a theory to work, it must have the ability to carry the concepts through to resolution within the context that it was created (Glaser, 1978). I believe that the conceptual categories embedded in the stages and dimensions speak for themselves and offer a road map to resolving the initiating issue. As Glaser (1978) pointed out, a theory is as good as its internal explanatory power. This means that it must show the connections of the variables to each other and must account for variations. Should another theory come out of the same data, then it is another theory altogether. "The proper attitude is simply to accept having discovered ideas. There are so many grounded theories!" (Glaser, 1978, p.137).

Criterion # 3: Does the theory have "grab" within the experience and reality of the participants?

"Grab" means that the theory must be interesting, useful and easy to remember (Glaser, 1978). It must be recognizable, particularly by people who are in the know or who are familiar with the substantive area of inquiry. According to Milleken and Schreiber (2001), the epistemology of grounded theory begins with who the knower is. To ensure that the grounded theory has "grab" within the experience and understanding of the participants, they must be engaged in the conceptualization of the grounded theory (Schreiber & MacDonald, 2001). Milleken and Schreiber (2001) contrasted grounded theory with quantitative methods where in the latter, the researcher is the expert while in the former the grounded theorist defers to the expertise of the participant who has the experience with the phenomenon being studied. This is crucial in shaping the role of the researcher and participants and for defining the parameters of the conduct of the research. Thus, the study created opportunities by which researchers engaged the participants, who are the MCHBs, in the analysis and construction of the meanings of their experience.

This study adopted a participatory and collaborative approach; the participants were involved in the critical aspects of the research: planning the research, instrument development, analysis and theory construction. Through the focus groups, the MCHB participants directly experienced taking their data from coding through to conceptualization. This engagement in an analytical and creative process of

constructing a theory was a strategy to ensure that the generative theory would authentically speak of and give meaning to the reality of the participants' experiences.

Finally, Glaser (1978) also noted that a theory that has "grab" is one that is interesting enough for people to remember and most importantly, that people will use. In Glaser's and Strauss's (1967) earlier work, they said a theory is usable in practical applications; prediction and explanation should be able to give practitioners understanding and some control of situations (p.3). The multicultural health brokering theory will have immediate applications to the work of the multicultural health brokers. It will help them to develop a competency framework that will guide the nurturing of promising and potential multicultural health brokers, and allows them to strengthen the capabilities of current multicultural health brokers. There are exciting potentials for creating awareness of the practice in the broad area of the "helping sector": advocating for the practice in reducing social inequalities and energizing ethnocultural communities to work for meaningful change. For example, the Multicultural Health Brokers Co-operative will be working for a formal recognition of the practice now that there is a research basis for its definition (MCHB Co-op Strategic Plan, 2002-2005). The MCHB Co-op is currently implementing a project called "All Together: A multicultural coalition for equity in health and well being", funded by Health Canada through the Voluntary Sector Initiative, that looks at direct citizen engagement in policy-development process – a concrete demonstration of Dimension 3 (Building community capacities) and Dimension 4 (Catalyzing institutional change).

X. Limitations of the collaborative theory building

The multicultural health brokering practice as conceptualized in the study involves three key actors: ethnic minority individuals, families and communities served by the MCHBs; the multicultural health brokers; and a service provider. To be able to generate a substantive theory for multicultural health brokering, the theoretical sample should have included all of the actors to allow a wider comparison of groups involved in the process. However, due to resource and time constraints as well as the urgency to address an issue vital to the MCHBs and the MCHB Co-op, the research focused on the MCHB experience. This study includes recommendations for further study on

multicultural health brokering with the two other actors in the process (See Recommendations section). Without the participation of the other two actors, generalizability of the theory is limited to the context of the multicultural health brokers.

Another limitation involves the difficulty of engaging all of the MCHBs in the analytical process. Because of their busy schedules, only 60% of the research participants participated in the focus groups. We do not know whether there would be significant differences or new information in generating the concepts had everyone participated. That is, the theoretical completeness may be enriched or strengthened with the additional perspectives of those who missed the discussions.

Language is a key limitation in the conduct of this research. English is the second language of all those interviewed including the researcher. The interviews and focus groups were conducted in English. There is the possibility that we might have lost meaningful data in the interviews and discussions of the focus groups. Jackson (1998) spoke about two important concepts in language translation that could cause miscommunication. The first and most obvious is vocabulary equivalence, or finding key words that have the same meaning in both languages. The second, and most difficult, is conceptual equivalence, which is finding a word in the culture with unique emotional and experiential associations. The more dissimilar the language and cultural experiences, the harder it is to find the accurate equivalent of a word. This is why those who are involved in translating languages would often say, "it loses something in translation". Perhaps the data would have been richer if the interviews had been conducted in the participants' own languages. Several questions came to mind as I was exploring the limitations of the study. Were the English words I have chosen to synthesize the participants' coding labels accurate to name the ideas that emerged? If the analyst were a native English speaker, would he or she have named the categories differently? How close and meaningful were those categories which were expressed in English to the experience of the research participants? These are some of the concerns that were observed during the research that may have limited the depth and sensitivity of theory construction.

Part Three

Conclusions and Recommendations

This chapter consists of two sections. The first section is the conclusion of the study, which will discuss the relevance of the theory of the multicultural health brokering practice in human ecology. The second section will present the study's recommendations in four areas of concern: the multicultural health brokering practice, the Multicultural Health Brokers Co-op, primary health care and future research.

I. Conclusion

This section will discuss the relevance of the grounded theory of multicultural health brokering within the human ecology framework, and how the theory addresses the assumption behind the critical social science perspectives. The role of the Multicultural Health Brokers Co-operative will also be defined in promoting the multicultural health brokering practice.

The theory of the multicultural health brokering practice as an adaptive strategy in human ecology

This study concludes that the grounded theory on the multicultural health brokering practice is an example of adaptive strategies that could be supported within the human ecology perspective. The human ecology perspective offers a theoretical framework to deepen the understanding of ethnic minority newcomers' experience and the relevance of the multicultural health brokering practice in influencing ethnic minority health. This perspective rests on three main assumptions in human ecology that help to describe the newcomer experience of ethnic minorities and the strategies they adopt to sustain themselves in the new environment. These assumptions state that: "1) Social and physical environments are interdependent and influence human behavior, development and quality of life; 2) Environment is a source of available resources; and 3) We can choose, design, or modify resources and environments to improve life and

well being, and we should do so" (Bubolz & Sontag, 1993.p. 421). Human ecology theorists such as Bubolz and Sontag believed that quality of life and the quality of the environment are interdependent, and individuals and families cannot be considered apart from the well-being of the whole system.

The concept of the social determinants of health demonstrates the interdependent relationship between human behaviour and the environment (First assumption). This concept describes conditions in the environment that influence the newcomers' vulnerability to ill health as well as their chances for better health. There is evidence that social determinants of health are the most powerful predictors of health among ethnic minority groups (Evans et al., 2001; Wilkinson & Marmot, 1998). According to Evans et al. (2001), these social determinants can be identified into four broad conceptual mechanisms: *social stratification* or the division of populations into different social positions or ranks (i.e. majority vs. minority); *differential exposure* to health-damaging conditions that poor people would most likely experience something compared to those who are not poor (i.e. poor nutrition, poor housing and chronic stress); *differential susceptibility* refers to the way two or more risk conditions can act synergistically to produce more devastating effects (i.e. poverty, social isolation, discrimination); and *differential consequences* are the results of the first three factors that precipitate a downward spiral and further risk of illness. Evans et al (2001) refer to this as the "*ill health entrapment*, the serious combination of poverty and marginalization that have cumulative effects over the course and transcend generations" (p.7). Interestingly, Wilkinson (2001) presents a provocative thesis of how inequalities in a society affect individuals and populations at the level of human biological processes and the societal impact. According to him, unequal societies breed inegalitarian relationships that create weak and unequal social relations. More powerful than material deprivation, low social status is a source of chronic stress and anxiety that diminishes one's emotional and physical resilience. At the societal level, comparisons of social status lead to social exclusion of population groups from resources and opportunities for mobility and advancement. Health inequities are an example of social exclusionary conditions; these exist when people have unequal access to society's resources such as employment,

housing, education, health care and clean environment – factors that society through the public sector are responsible for or can do something for.

> In important ways, a nation's health inequities may be seen as a barometer of its citizens' experiences of social justice and human rights. Thus remedies for health inequities must come not only from the health sector but also from broad social policies, including fair access to education, job training, gender equity, environmental risk reduction and protection from impoverishment. The analysis of health inequity must be linked to health outcomes and more generally to quality of life and essential freedoms. Health equity is best thought of not as a social goal in and of itself, but as inherently embedded in the pursuit of social justice. (Evans et al., 2001,p.3)

The concept of social determinants also explains ethnic minority health experience that resonates with the critical social science perspective (CSSP) espoused within the human ecology framework. The ability of the CSSP to make visible issues of power and oppression that are most often hidden from people's experience helps to understand why linguistic barriers experienced by ethnic minorities in accessing services are beyond an issue of communication but also of policies and programs that are not responsive to the needs of populations who have been marginalized from resources and opportunities in society. This study showed the growing evidence in the literature about the persistent inequalities of immigrants and refugees in the area of employment opportunities and career mobility, housing options, access to health care and social supports as well as civic and political participation (Galabuzi, 2001; Health Canada, 1999a; Hyman, 2001).

The second assumption in the human ecology perspective indicates the need to explore the environment to sustain life. This is closely linked with the third assumption that speaks of people's ability to modify the environment in order to respond to the need to survive and maintain life. Adaptation is one of the key processes in human ecology and refers to "behavior of the living systems that changes the state of or structure of the system, the environment, or both" (Bubolz & Sontag, 1993.p. 4233). According to Bubolz and Sontag (1993), human beings must not simply adapt to the environment but must modify it when the environment can no longer support their survival and sustenance of life. This is a process necessary to the growth and progress of society, the living system. Following the definition of adaptation offered by Bubolz and Sontag (1993), while immigrants and refugee newcomers must adapt to their environment, they can also

choose to change the environment when it cannot provide them with the resources to support and maintain their needs and aspirations as human beings.

Decisions and actions that people make in order to respond and adjust as well as plan for environmental contingencies are referred to as adaptive strategies. They are concrete expressions of human-environmental interaction fundamental to the survival and sustenance of life. Settlement and integration create environmental contingencies that compel immigrants and refugees to devise ways to cope with the new environment and sustain a quality of life that meets their aspirations of a better future. If survival is the nurturing of life, then health and well-being become the locus of adaptive strategies. Health is an important resource to every newcomer as he/she begins to aspire to a better life and a hopeful future in the new country.

The multicultural health brokering practice as an adaptive strategy offers an intermediate intervention for immigrants and refugees to gain access to resources and opportunities that increase their chances for successful settlement and integration in the new country. In this study, the history of multicultural health brokering in Edmonton described how ethnic minorities evolved a community response to the issues of isolation, poverty and limited opportunities for advancement. The theory on multicultural health brokering explains the stages and dimensions by which ethnic minorities could achieve equity of access to opportunities for health and well-being. By brokering support for ethnic minority individuals, families and communities, multicultural health brokers are contributing to improving the prospects and life chances of newcomers struggling to survive in an unfamiliar environment. Having someone to help a newcomer navigate the intricate web of institutional systems could make settlement and integration a healthful process. Multicultural health brokering as an adaptive strategy builds social connections that are essential to buffer the harmful effects of dominant hierarchies. Dominant hierarchies refer to the societal structure that assigns positions of status such as the presence of majority and minority populations that have designated social positions and privileges (King & Williams, 1996). Wilkinson (2001) cites studies with non-human primates on dominance, which reveal behavioural patterns that illuminate certain human behaviours. " Where dominant hierarchies exist among non-human primates, social alliances are an important source of protection"

(Wilkinson, 2001, p. 32). Friendships, which are the basis for forming social bonds, are outcomes of multicultural health brokering work and examples of egalitarian alliances. There is an empowering dimension in such social interaction that is founded on the value of people with gifts to bring to a relationship. Multicultural health brokering is a relevant adaptive strategy that will emerge in unequal societies to address issues of power and inequity. Only when there is equality of power in society and cultural pluralism is the dominant paradigm will the cultural brokers work themselves out of a job (Tripp-Reimer, & Brink, 1985).

The Role of the Multicultural Health Brokers Co-operative

The Multicultural Health Brokers Co-op is the appropriate organizational vehicle for advancing the multicultural health brokering practice as an example of an adaptive strategy that strives to address individual needs for survival but also encompasses broader societal concerns that sustain quality of life. The values of equity, social justice and democratic governance that underpin the Co-op's work with ethnic minority communities assign a catalytic role to the organization's mandate. As an active agent of social change, this role involves making social inequalities more pronounced and visible, advocating for equitable health policies and enjoining cross-sectoral participation in reducing economic and social disparities. This role demonstrates grounding values that contribute to the betterment of society; the ultimate goal of human ecology (Bubolz & Sontag, 1993). According to Bubolz and Sontag (1993), the values of economic adequacy, justice, freedom and peacefulness are what drive human ecology as a discipline to pay attention to groups and subcultures "who lack power, self-determination, and access to resources and who experience discrimination and prejudice" (p.427). These groups include racial and ethnic minorities, the handicapped, women, the poor and the old (Bubolz & Sontag, 1993).

Lastly, the MCHB Co-op stands at the forefront of demonstrating the co-operative organization as an example of inclusive and equitable social structures that can create an impact on individual and community health. The origin of co-operatives is rooted in the concept of reciprocity, a process of gift-giving and sharing within a relationship of mutuality. As such, co-operatives are inherently egalitarian in the

relationship among members of the organization as well as in sharing benefits from the organization. The MCHB Co-op is an example of equity in practice; organization members are governed not by traditional and dominant organizational hierarchies but by shared power relations guided by a commitment to collective goals and respect for diversity of capacities and strengths among members. The Co-op strongly believes that real power resides in its membership, thus creating a transformative value system that guides the day-to-day work of the multicultural health brokers. Humility, respect, sacredness, reciprocity and love are values that underpin the structures and processes of organizational development, and they are essential to the health and well being of the Co-op members.

II. Recommendations

The recommendations in this section offer suggestions on how the practice can further strengthen the capabilities of the multicultural health brokers through competency framework based on the theory of the multicultural health brokering practice. Recommendations for the MCHB Co-op are also included to address the organization's development issues as discussed in the previous chapter. Current interest in primary health care is an appropriate context to suggest the relevance of multicultural health brokering in the health care system. Lastly, directions for future research that broadens the research on multicultural health brokering will contribute to enriching existing theories on cultural brokering.

A competency framework for the multicultural health brokering practice

The multicultural health brokering model based on the grounded theory developed in this research provides a basis for articulating the elements of a competency framework for improving the practice. The competency framework is aimed at defining the scope of the MCHB practice based on the stages and dimensions described in the multicultural health brokering theory.

The competency framework will identify practice settings based on the four dimensions of the work and the expected outcomes of the practice in each of the settings. It will embody the ethical values and principles of the practice based on the

processes involved in each stage. For example, issues of confidentiality can be explored and resolved recognizing that the clients of the multicultural health brokers may be someone they know from their community. The stages and dimensions in multicultural health brokering will also determine the types of supports and services that the MCHB can offer to individuals, families, groups and communities.

The competency framework will also identify the essential dimensions of what makes a multicultural health broker, carefully considering that the practice is as much a reflection of what makes a person. The role of the community in nurturing potential multicultural health brokers must be essayed into this exploration.

The framework will also include a process for reflective evaluation that engages individuals, families, groups and communities in determining outcomes will serve as a basis for continuously enhancing the MCHB practice. The design of such a process is suggested to involve those who have experienced the support of a multicultural health broker. Lastly, the competency framework must quintessentially mirror the foundational philosophies and organizational values of the MCHB Co-op.

Areas for organization development for the MCHB Co-op

Responding to organizational development issues discussed in the previous chapter, the following are activities that the MCHB Co-op can undertake as an organization.

Building shared leadership

Formalizing processes for shared leadership in the Co-op involves defining the active role of the Board of Directors as a collective body for providing leadership and direction in the internal and external tasks of the organization. These roles should be defined by the general membership along the areas of: decision-making process, performance evaluation, conflict resolution, organization planning and administration. The Co-op needs to delegate tasks among its Board of Directors and the membership with the accompanying recognition of the performance of these tasks. The Co-op members need these opportunities to build their organizational skills and to establish a continuing leadership pool among its members.

Creating a strategic vision

This means enhancing organizational planning by focusing on outcomes that include integrating revenue targets with community needs and employment commitment to Co-op members. It is proposed that the Co-op undertake year-end planning for each incoming year to determine its revenue targets and to identify project development opportunities. It is assumed that the planning will include, as much as possible, community expressions of needs and interest. Perhaps, as a long-term vision, the community served by the MCHBs will be involved in the Co-op's planning process.

Continuing co-operative education

Continuing education on the principles and process of co-operative development is essential in building organizational capacities. The MCHB Co-op members need to deepen their knowledge of a workers' co-operative, how it works and how it can serve their needs and aspirations. One of the significant aspects of co-operative development is a shift in the role of multicultural health brokers from service providers/members of an organization to owner-operator of a business organization. This has profound implications in motivating members to participate in organizational development work. The involvement of members in the growth of the organization becomes an investment as an owner of the business.

A culturally competent primary health care

This study recommends that the multicultural health brokering practice be part of primary health care initiatives that are aimed at reaching vulnerable and marginalized populations in culturally diverse communities. The implementation of the Health Innovation Fund (Health Innovation Fund Project, 2001) demonstrates support for innovative ways to implement primary health care in the provinces.

The World Health Organization at the Alma Ata Conference introduced *primary health care* (PHC) as the key to achieving health for all in the year 2000. The impetus for the development of the PHC model was the recognition of inequalities in health between and within countries (World Health Organization Regional Office for Europe, 1985). Primary health care is defined as:

> Essential health care based on the practical, scientifically sound and socially acceptable

> methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, family, and community with the national health system bridging health care as close as possible to where people live and work, constitutes the first element of a continuing health care process. (World Health Organization, 1978, p.21)

The primary health (PHC) model embodies five basic principles that are founded on a philosophy of equity and social justice. These principles are accessibility, community participation, health promotion, intersectoral collaboration and appropriate technology. PHC services are directed to people who are most vulnerable and at high risk to illness and disease and who would most likely have multiple barriers accessing health care (World Health Organization Regional Office for Europe, 1985). Embedded in the PHC principles is a holistic view of health where at the level of the individual, PHC service is concerned with the whole person in the context of their family and community (World Health Organization Regional Office for Europe, 1985). At the societal level, PHC focuses on health policies aimed at addressing the broad determinants of health (Taylor, 1992).

Multicultural health brokering fits well within the primary health care model because it essentially shares the same philosophical foundations. Multicultural health brokering flourishes in settings where marginality and powerlessness exist (Jezewski, 1993; Press, 1969). The practice resonates with the five principles of primary health care.

Accessibility means reducing the barriers in obtaining health care services and bringing resources and opportunities to support and maintain people's health.

Multicultural health brokers operate in people's homes and in the community. They are the first contact to the health system. The outcome of the multicultural health brokering practice is achieving equity of access to health for those who are marginalized and isolated. The multicultural health brokers are the bridge for the population to gain access to health-enhancing and health-supporting resources. The accessibility of the multicultural health brokers is not only defined by their physical proximity to the communities they serve, but also by the shared language and cultures that reduce barriers. The multicultural health brokering practice is intentional in addressing equity

issues by leveraging support for people and communities while building their capability to assume the responsibility of advocating for themselves.

Health promotion is the process of enabling people to exert control over factors and conditions that influence health. PHC focuses on efforts aimed at supporting healthy lifestyles, early screening and detection and addressing the collective factors that affect health such as housing, pollution and poverty. All actions to promote health occur within a social context. This means that strategies in health promotion should be continually adapted to ensure their social and cultural relevance. There is evidence to show that successful primary health care programs in many countries have used health promotion strategies that are congruent with community traditions, values and beliefs (Restreppo, 2000). The four dimensions of the multicultural health brokering practice demonstrate the various levels of health promotion efforts that are aimed at building people's autonomy and a community's capacity to act as agents of their own health.

Community/public participation means placing importance in developing people's capacities to participate in decisions about their health, achieve important improvements in health conditions and strengthen their capacity to respond to new challenges and opportunities (Mittelmark, 2000). One of the important processes in the multicultural health brokering practice is advocacy, defined by Jezewski (1993) as the "act of enabling individuals and groups to exercise self-determination" (p.79). Multicultural health brokers facilitate dialogue with groups and communities about the broader issues that affect their health, moving beyond the illness problems of individuals to policies and programs that support community health. The multicultural health brokers serve as catalysts and animators that help ethnic minorities articulate health issues within their communities and to then address them to the appropriate agencies and institutions. The multicultural health brokering practice fosters community participation by being attentive to the cultural traditions of collective actions.

Intersectoral collaboration recognizes that the health sector is only one of the players in promoting health and well-being, and that its success and effectiveness is strongly influenced by the partnerships and alliances it has built with other sectors. In cultural brokering, networking is a key process in providing support to minority families who know that the attendant social and economic issues impacting their health

fall within the domain of other sectors (Jezewski, 1993). In the theory of the multicultural brokering practice, networking is similar to connecting families to resources or creating alliances and partnerships. The MCHBs work closely with other health professionals other than the physician and the nurse; social service workers are included as well. At the policy level, the MCHB Co-op is actively seeking alliances with other sectors to promote healthy public policy. For instance, the MCHB Co-op forms partnerships with the social services sector to advocate policies that support family well-being or else it works with community-based organizations to advocate for cultural responsiveness in programs and services.

Appropriate technology means using local and indigenous resources, when appropriate, that could positively contribute to individual and community health. The multicultural health brokering practice potentially offers cost-effective mechanisms to promote the appropriate use of health services. The effectiveness of multicultural health brokers as indigenous health educators, blending western health concepts with indigenous traditions, facilitates positive health outcomes. Karen Patzer (1997) calculated the potential savings for the health care system as a result of the work of the multicultural health brokers in preventive perinatal health education; their work increases breastfeeding rates, improves birth weights of newborns and prevents post-natal illness that results in hospitalization of the mother and child. Using 1996 American estimates, Patzer (1997) cited studies showing that breastfeeding can save $400-$800 per family per year for formula cost. Likewise, appropriate and adequate pre-natal support can save the health care system $500 - $1,000 for the cost of caring for a low-birth weight baby.

The experience of primary health care programs in developing countries using indigenous health workers has demonstrated successful outcomes in primary prevention and health promotion such as improving the immunization rates of infants, increasing the rate of early screening for breast cancer and the adoption of positive health behaviours (Sharp et al., 1998; Sidebotham, 1998). Even within developed countries, indigenous workers have contributed to reducing health care costs but more importantly have provided accessible and affordable service (Eng et al., 1997; World Health Organization Regional Office for Europe, 1985; Witmer et al., 1995). For instance,

the use of lay health advisors had increased treatment completion for TB in New York (Klein & Naizby, 1995). Hispanic community health workers improved the completion of a diabetes education program (Corkery et al., 1997). By increasing access to primary health care services, Witmer (1995) noted that community health workers could prevent unnecessary reliance on costly emergency department and specialty services. The multicultural health brokering practice offers vast potentials to reach populations who are isolated and marginalized and who are most likely at greater health risk than the general population. Multicultural health brokers provide a crucial link between communities and institutions and in the process make the principles of primary health care become meaningful and useful in providing equitable access to health-promoting and health-enhancing resources and opportunities.

Suggestions for future research

There is a need to complete the next step in the grounded theory on the multicultural health brokering practice by including two key actors involved in the process: the ethnic minority clients and communities, and the service providers. The multicultural health brokering theory must also articulate their experience in the process. Potential areas for further research include describing the experience of people served by multicultural health brokers, including those who were provided one-on-one support and those who have participated in group programs. This promises to be a rich source of new information that could be added into the multicultural health brokering theory. Similarly, the insights of service providers who have worked and collaborated with the multicultural health brokers will offer fresh perspectives of the multicultural health brokering practice within an institutional context. Another interesting study that could have significant implications for the health care system is an exploration into the potential of co-operatives in the delivery of health services, especially in communities who are isolated and marginalized from the formal health system. Co-operatives are self-sustaining organizations that are created based on the needs and context of the community. Given the appropriate support and opportunity, cooperatives can be developed into locality-focused health care delivery systems that are accessible and reliance in these communities.

III. A final note: Issues of the heart and imaginings of the mind

The strong grounding of people's experiences inherent in multicultural health brokering is implicit in the multicultural health brokering practice. Kurin (1997) aptly describes this grounding:

> The culture broker needs to be humble enough to listen to the voice of the people, the exemplars of the culture they represented... brokerage involves active and respectful engagement... operates in an egalitarian way, recognizing the interests of the parties, the varying types of power – cultural, coercive, fiscal that might brought to bear in negotiating their transformation and fulfillment" (p. 387)... We have so much to learn from them... considering that the most important things in life are brokered - peace and justice, power and wealth, and even love and marriage (Kurin, 1997p. 390).

When I think of the of the multicultural health brokers, I am reminded of a story I read in Meredith Minkler's book, *Community Organizing and Community Building for Health*(1998). When working with issues of power, inequality and social change, Minkler (1998) speaks about the "conscious contrarians" who can be described along three dimensions: sharing a worldview that is characterized by a strong sense of what is just; a power analysis that is rooted in the critical awareness that wealth, health and life chances are determined by political, economic and socio-cultural factors; and deliberate career choices that seek out jobs that have the possibility of promoting change. She adds a fourth dimension, which is the desire "to do things differently". This counter consciousness is borrowed from the traditions of the Heyoekahs. Called "sacred clowns" and also known as contrarians, their role was to "keep people from getting stuck in rigid ways of thinking and living". The "sacred clowns" would walk and dance backwards and do everything contrary to the norm. They were a constant reminder to everyone in the community that no problem can be too complex if you challenged traditional ways of thinking and always posed the critical questions. The multicultural health brokering practice dares us to free ourselves from narrow and rigid ways of thinking and allows us to experience the liberating and expansive process of thoughtful and critical thinking.

Finally, the practice of multicultural health brokering ushers in a progressive approach to the notion of multiculturalism. It attempts to advance beyond the Canadian mosaic's ideals of tolerance and accommodation of cultural differences towards a

process of negotiation and mediation of differences. Let me offer a new metaphor, that of a creatively designed Canadian quilt where discernible patterns of colours and designs are sewn together into a coherent, functional and identifiable whole. Multicultural health brokers operate at the borders between cultural patterns and caringly find the right threads to sew the edges together, and in the process create a blended pattern, the product of transformation and change.

> *" I always felt that the action most worth watching is not the center of things but where edges meet. I like shorelines, weather fronts and international borders. There are interesting frictions and incongruities in these places, and often, if you stand at the point of tangency, you can see both sides better than if you were in the middle of either one."*
>
> Anne Fadiman, *The Spirit Catches You and You Fall Down:*
> New York, 1999

Reference List

Aday, L. U. (1993). Equity, Accessibility and Ethical Issues. American Behavioral Scientist, 36(6), 724-741.

Addy, J. A. (1996). Issues of Access: What is Going on in Health Care? Nursing Economics, 14(5).

Agar, M., & MacDonald, J. (1995). Focus Groups and Ethnography. Human Organization, 54(1).

Aguilar, J. L. (1985). Insider Research: An Ethnography of a Debate. In D. A. Messerschhmidt (Ed.), Anthropologists at Home in North America: Methods and issues in the study of one's own society. Cambridge: Cambridge University Press.

Alleyne, Dr. G. A. O. (2000). Opening Address. Fifth Global Conference on Health Promotion: Bridging the Equity Gap. World Health Organization.

Alvesson, M., & Skoldberg, K. (2000). Reflexive Methodology: New Vistas for Qualitative Research. London: Sage Publications.

Amick III, B., Levine, S., Tarlov, A., & Walsh, D. (1995). Introduction. In B. Amick III, S. Levine, A. Tarlov, & D. Walsh (Eds.), Society and Health (pp. 3-17). New York: Oxford University Press.

Annells, M. (1996). Grounded Theory: Philosophical Perspectives, Paradigm of Inquiry, and Postmodernism. Qualitative Health Research, 6(3), 379-81.

Antonucci, T. C., & Jackson. J. S. (1990). The role of reciprocity in social support. In B. R. Sarason, I. G. Sarason, & G. R. Pierce (Eds.), Social Support: an Interactional View (pp. 173-209). New York: Wiley.

Asbury, J.-E. (1995). Overview of Focus Group Research. Qualitative Health Research, 5(4), 414-420.

Baker, C., Wuest, J., & Stern, P. N. (1992). Method Slurring: the grounded theory/phenomenology example. Journal of Advanced Nursing, 17, 1355-60.

Baker, E., Bouldin, N., Durham, M., Lowell, M., Gonzalez, M., Jodaitis, N., Cruz, L., Torres, I., Torres, M., & Adams, S. (1997). The Latino Health Advocacy Program: Collaborative Lay Health Advisor Approach. Health Education & Behavior, 24, 495-515.

Ballem, P. (1998). The Challenge of Diversity in the Delivery of Women's Health Care. Canadian Medical Association Journal, 159(4), 336-338.

Barnes, D. M. (1996). An Analysis of the Grounded Theory Method and the Concept of Culture. Qualitative Health Research, 6(3), 429-431.

Bartunek, J. M., & Louis, M. R. (1996). Insider/Outsider Team Research. Thousand Oaks: Sage Publication.

Basavarajappa, K. G., & Jones, F. (1999). Visible Minority Income Differences. In S. Halli, & L. Driedger (Eds.), Immigrant Canada: Demograhic, Economic and Social Challenges (pp. 230-260). Toronto: University of Toronto Press.

Bews, J. W. (1935). Human Ecology. London: Oxford University Press.

Birch, S., & Abelson, J. (1993). Is Reasonable Access What We Want? Implications of, and Challenges To, Current Canadian Policy on Equity in Health Care. International Journal of Health Services, 23(4), 629-653.

Blackford, J., Street, A., & Parsons, C. (1997). Breaking down language barriers in clinical practice. Contemporary Nurse, 6(1), 15-21.

Booker, V. K. R. J. G., Bonnie, J., Najera, L. G., & Stewart, G. (1997). Changes in Empowerment: Effects of Participation in a Lay Health Promotion Program. Health Education & Behavior, 24(4), 452-465.

Bowes, A. (Evaluating an Empowering Research Strategy: Reflections on Action Research with South Asian Women [Web Page]. URL http://www.socresonline.org.uk/1/1/1.html [2000, April].

Bronfenbrenner, U. (1979). The Ecology of Human Development. Cambridge, Massachusetts: Harvard University Press.

Bubolz, M. (1995). Use of critical Social Science Perspective in Human Ecology. In Human Ecology: Progress through Integrative Perspectives Michigan: The Society for Human Ecology.

Bubolz, M.., & Sontag, M. S. (1993). Human Ecology Theories. In P.G. Boss. ,L.R. Doherty, &. S.K. Steinmetz, CEds.), Sourcebook of Family Theories and Methods: A contextual approach. New York: Plenum Press.

Calman, K. C. (1997). Equity, Poverty and Health for All. BMJ, 314(7088), 1187-1192.

Camphinha-Bacote, J. (1991). The Process of Cultural Competence: A culturally competent model of care. Wyoming, Ohio: Transcultural C.A.R.E. Associates.

Canadian Immigration and Citizenship. (1999) Facts and Figures: 1998 Immigration Overview [Web Page]. URL http://www. cic.ca [1999].

Cancian, F. M. (1993). Conflicts between Activist Research and Academic Success: Participatory Research and Alternative Strategies. American Sociologist, 24(1), 92, 15 p.

Cantrell, R., & Walker, M. (1993). Participatory Action Research and Policy Making: Consumers and non-consumers deliberate the Reauthorization of the Rehabilitation Act. Rehabilitation Counselling Bulletin, 37(1), 37-49.

Carey, M. A. (1994). The group effect in focus groups: Planning, implementing and interpreting focus group research. In J. Morse (Ed.), Critical Issues in Qualitative Research Methods. Thousand Oaks, CA: Sage.

Carey. M.A. (1995). Comment: Concerns in the Analysis of Focus Group Data. Qualitative Health Research, 5 (4), 487-495.

Cave, A., Maharaj, U., Gibson, N., & Jackson, E. (1995). Physicians and Immigrant Patients. Canadian Family Physician, 41.

ChapmanWalsh , D., Sorenson, G., & Leonard, L. (1995). Gender, Health and Cigarette Smoking. In B. C. Amick III, S. Levine, A. R. Tarlov, & D. Chapman Walsh (Eds.), Society and Health (pp. 93-132). New York: Oxford University Press.

Chenitz, W. C., & Swanson, J. M. (1986). Qualitative Research Using Grounded Theory. In W. C. Chenitz, & J. M. Swanson (Eds.), From Practice to Grounded Theory: Qualitative Research in Nursing (pp. 3-16). Menlo Park, California: Addison-Wesley Publishing Company.

Clement, W. (1999). Inequality of access: Characteristics of the Canadian Corporate Elite. In M. Reza Nakhaie (Ed.), Debate on Social Inequality: Class, gender and ethnicity in Canada (pp. 76-88). Toronto: Harcourt Brace Canada.

Cobb, S. (1976). Social Support as a moderator of life stress. Psychosomatic Medicine, 38, 300-314.

Cohen-Rosenthal, E. (Health, Ecology and Learning: A Perspective on Change [Web Page]. URL http://www.cfe.cornell.edu/wei/papers/health.html [2000, April].

Cohen, S., Mermelstein, R., Karmarck, T., & Hoberman, H. M. (1985). Measuring the functional components of social support. In I. G. Sarason, & B. R. Sarason (Eds.), Social Support: Theory, Research and Application (pp. 73-94). Boston: Nijhoff.

Collins Concise Dictionary & Thesaurus. (1995). Glasgow: HarperCollinsPublishers.

Collins, T. (1995). Models of health: pervasive, persuasive and politically charged. Health Promotion International, 4(4), 317-323.

Corin, E. (1995). The cultural frame: context and meaning in the construction of health. In B. Amick III, S. Levine, A. Tarlov, & D. Walsh (Eds.), Society and Health. (pp. 272-304). Oxford : Oxford Press.

Corkery, E., Palmer, C., Foley, M., Schecter, C., Frisher, L., & Roman, S. (1997). Effect of Bicultural Community Health Workers on Completion of Diabetes Education in

a Hispanic Population. Diabetes Care, 20(3), 254-257.

Cornforth, C., Thomas, A., Lewis, A., & Spear, R. (1988). Developing Successful Worker Co-operatives. London: Sage Publications.

Coultier, J. (1999). Social and Demographic Trends and the Canadian Justice System. Meeting of the National Joint Committee Canadian Centre for Justice Statistics.

Creswell, J. (1998). Qualitative Inquiry and Research Designs: Choosing among Five Traditions. Thousand Oaks, California: SAGE Publications.

D'Avanzo, C. E. (1992). Bridging the Cultural Gap with Southeast Asians. MCN, 17, 204-208.

Daniels, N. (1982). Equity of Access to Health Care. Health and Society, 60(1), 51-81.

Deshler, D., & Ewert, M. (Participatory Action Research: Traditions and Major Assumptions [Web Page]. URL http://www.PARnet.org/parchive/docs/deshler_95/ [2000, April].

Dixon, J. (2000). Resource Reviews: *Social Determinants of Health* by Michael Marmot and Richard Wilkinson. Health Promotion International, 15(1), 87-89.

Donahue, J. M. (1986). The Profession and the People: Primary Health Care in Nicaragua. Human Organization, 45(2), 96-103.

Eakin, J., Robertson, A., Poland, B.,C. D., & Edwards, R. (1996). Towards a Critical Social Science Perspective on Health Promotion Research. Health Promotion International, 11(2), 157-165.

Ell, K. (1996). Social Networks, Social Support and Coping with Serious Illness: The Family Connection. Social Science & Medicine, 42(2), 173-183.

Eng, E., Parker, E., & Harlan, C. (1997). Lay Health Advisors Intervention Strategies: A Continuum from Natural Helping to Paraprofessional Helping. Health Education & Behavior, 24(4), 413-418.

Evans, T., Whitehead, M., Wirth, M., & Epstein, H. (2001). Summary. T. Evans, M. Whitehead, F. Diderichson, A. Briurya, & M. Wirth (Eds), Challenging Inequities in Health: From Ethics to Action (pp. 1-18). New York: Oxford University Press.

Fairbarns, B. (1990). Social Bases of Cooperation: Historical Examples and Contemporary Questions. In M. Fulton (Ed.), Cooperative Organizations and Canadian Society: Popular Institutions and Dilimmas of Change (pp. 70-77). Toronto: University of Toronto.

Fairbarns, K., Axworthy, C. S., Fulton, M., Hammond, L. K., & Laycock, D. (1990). Cooperative Institutions: Five Disciplinary Perspectives. In M. Fulton (Ed.), Cooperative Organizations and Canadian Society: Popular Institutions and the

Dilemmas of Change . Toronto: University of Toronto Press.

Found, W. C. (1997). Evaluating Participatory Research Supported by the International Development Research Centre. Knowledge and Policy, 10(1/2), 109, 14 p.

Freedman, L. P. (1999). Reflections on Emerging Frameworks of Health and Human Rights. In J. M. Mann, S. Gruskin, M. A. Grodin, & G. J. Annas (Eds.), Health and Human Rights: A Reader (pp. 227-252). New York: Routledge.

Galabuzi, G.-E. (2001). Canada's Creeping Economic Apartheid. Toronto, Ontario: CSJ Foundation.

Geertz, C. (1960). The Javanese Kijaji: The Changing Role of a Cultural Broker. Comparative Studies in Sociology and History, 2, p. 228-249.

Glaser, B. (1978). Theoretical Sensitivity: Advances in the Methodology of Grounded Theory. Mill Valley, CA: Sociology Press.

Glaser, B. (1992). Basics of grounded theory analysis. Mill Vallet, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine Publishing Company.

Guerrero, J. L. (Research Paradigm Shift: Participatory Action Research [Web Page]. URL http://internetwork.sdsu.edu/projects/rrtcp/pubs/par.html [2000, April].

Guilford, J. (2000). Making the Case for Social and Economic Exclusion. Halifax, Nova Scotia: Health Canada, Atlantic Regional Office.

Gutierrezm, L. M., & Lewis, E. A. (1998). Education, Participation and Capacity Building in Community Organizing with Women of Color. In M. Minkler (Ed.), Community Organizing & Community Building for Health (pp. 216-229). New Jersey: Rutgers University Press.

Hall, B. L. (1992). From Margins to Center? The Development and Purpose of Participatory Research. American Sociologist, 23(4), 15, 14 p.

Halli, S. S., & Kazemipur, A. (1998) Plight of Immigrants: The Spatial Concentration of Poverty in Canada [Web Page]. URL http://ultratext.hil.unb.ca/Texts/CJRS/b...tory=Spring97/halli/

Hancock, T. (1993). Health, human development and the community ecosystems: three ecological models. Health Promotion International, 8, 41-47.

Health Canada. (1999a) Canadian Research on Immigration and Health [Web Page]. URL http://www.hc-sc.gc.ca/iacg-dgiac/nhrdp/metropolis/ cirh_pdf_index_e.htm.[2000, June 30]

Health Canada. (1999b). Taking Action on Population Health: A Position Paper for

Health Promotion Programs Branch Staff.

Henderson, D. (1995). Consciousness raising in participatory research: Method and methodology for emancipatory nursing inquiry. Advances in Nursing Science, 17(3), 58-69.

Hennestad, B. W. (2000). Implementing Participative Management: Transition Issues from the Field. Journal of Applied Behavioral Science, 36(3), 314-336.

Henry, T., & Tator, C. (1999). State Policy as a Racialized Discourse: Multiculturalism, Charter and Employment Equity. In P. Li (Ed.), Race and Ethnic Relations in Canada (2nd ed., pp. 88-155). Toronto: Oxford University Press Canada.

Hill, M. N., Bone, L. R., & Butz, A. M. (1996). Enhancing the role of community health workers in research. Image Journal of Nursing Scholarship, 28(3), 221-226.

Hopkins, N., Ekpo, M., Heileman, J., Michtom , M., Osterweil, A., Sieber, R. T., & Smith, G. (1977). Brokers and Symbols in American Urban Life. Anthropological Quarterly, 50.

Hughes, D., & DuMont, K. (1993). Using Focus Groups to Facilitate Culturally Anchored Research. American Journal of Community Psychology, 21(6), 775-780.

Hupcey, J. (1998). Clarifying the social support theory-research linkage. Journal of Advanced Nursing, 27 (6), 1231-1242.

Hurdle, D. (2001). Social Support: A Critical Factor in Women's Health Promotion. Health and Social Work, 26(2), 72-80.

Hyman, I. (2001). Immigration and Health. Toronto: Health Canada.

Idali Torres, M. (1998). Assessing Health in an Urban Neighborhood: Community Process, Data Results and Implications for Practice. Journal of Community Health, 23(3), 211-230.

International Society for Equity in Health. (Working definitions) [Web Page]. URL http://www.iseqh.org/workdef.htm [2002, April 8].

Israel, B., Schulz, A., Parker, E., & Becker, A. (1998). Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health. Annual Review of Public Health, 19, 173-202.

Jackson, D., Brady, W., & Stein, I. (1999). Towards (re) conciliation: (re) constructing relationships between indigenous health workers and nurses. Journal of Advanced Nursing, 29(1), 97-103.

Jacobson, W. B. (2001). Beyond Therapy: Bringing social work back to human service reform. Social Work, 46(1), 51-62.

Jezewski, M. A. (1989). Using a Grounded Theory Method to Develop a Model of Culture Brokering in a Migrant Farmworker Health Care Setting. DAI-A, 50(6), 1713, 287p.

Jezewski, M. A. (1990). Culture Brokering in Migrant Farmworker Health Care. Western Journal of Nursing Research, 12(4), 497-513.

Jezewski, M. A. (1993). Culture Brokering as a Model for Advocacy. Nursing and Health Care, 14(2), 78-85.

Jezewski, M. A. (1994). Do-not-resuscitate status: conflict and culture brokering in critical care units. Heart & Lung, 23(6), 458-464.

Jezewski, M. A. (1995). Evolution of a grounded theory: conflict resolution through culture brokering. Advances in Nursing Science, 17(3), 14-30.

Jourdain, A. (2000). Equity of a health system. European Journal of Public Health, 10(2), 138-142.

Kagawa-Singer, M., & Chung, R. (1994). A paradigm of culturally-based care in ethnic minority populations. J Community Psychology , 22, 192-207.

Kearney M. (2001). New Directions in Grounded Formal Theory. In R. S. Schreiber, & P. N. Stern (Eds.), Using Grounded Theory in Nursing (pp. 227-246). New York: Springer Publications.

Kelly, K. J., & Van Vlaenderen, H. (1996). Dynamics of participation in a community health project. Social Science Medicine, 42(9), 1235-1246.

King, G., & Williams, D. (1996). Race and Health: A multidimensional approach to African-American Health. B. Amick III, S. Levine, A. Tarlov, & D. Walsh (Eds.), Society and Health (pp. 93-130). New York: Oxford University Press.

Kirkmayer, L., du Fort, G., Young, A., Weinfled, W., & Lasry, M. (1996). Pathways and barriers to mental health care in an urban multicultural miliey: An epidemiological and ethnographic study. Montreal: Sir Mortimer B. Davis - Jewish General Hospital.

Klein, S., & Naizby, B. (1995). New Linkages for Tuberculosis Prevention and Control in New York City: Innovative Use of Non-Traditional Providers to Enhance the Completion of Therapy. Journal of Community Health, 20(1), 5-12.

Kothari, B., & Fundacion Sabiduria Indigena (FSI). (1997). Rights to the Benefits of Research: Compensating Indigenous Peoples for their Intellectual Contribution. Human Organization, 56(2).

Kurin, R. (1997). Reflections of a Cultural Broker: A view from the Smithsonian. Washington D.C.: Smithsonian.

Labonte, R. (1993). Issues in Health Promotion Practice.Series#3. Health Promotion and Empowerment Practice Frameworks. Toronto: University of Toronto.

Labonte, R. (1998). Community, Community Development and the Forming of Authentic Partnerships: Some critical reflections. In M. Minkler (Ed.), Community Organizing & Community Building for Health (pp. 88-102). New Jersey: Rutgers University Press.

Lance, R., & Clifton, R. (1999). Exploring the Ideology of Canadian Multiculturalism. R. M. Nakhaie (Ed.), Debates on Social Inequality: Class, Gender and Ethnicity in Canada (pp. 312-317). Toronto: Harcourt, Brace & Company.

Laroche, M. (2000). Health Status and Health Services Utilization of Canada's Immigrant and Non-Immigrant Populations. Canadian Public Policy, 26(1), 51-75.

Last, J. M. (1998). Public Health and Human Ecology. Stamford, Connecticut: Appleton & Lange.

Lautard, G., & Guppy, N. (1999). Revisiting the Vertical Mosaic: Occupational Stratification among Canadian Ethnic Groups. In P. S. Li (Ed.), Race and Ethnic Relations in Canada (pp. 219-252). Toronto: Oxford University Press.

Lee, K. Urban Poverty in Canada [Web Page]. URL http://www.ccsd/ca [2000, April].

Li, P. (1999). Race and Ethnicity. In P. Li (Ed.), Race and Ethnic Relations in Canada (pp. 3-22). Toronto: Oxford University Press Canada.

Lin, N. (1979). Social Support, Stressful Events, and illness: a model and an empirical test. Journal of Health and Social Behavior, 20, 108-119.

Longos, D. (Diversity Presentation [Web Page]. URL http://www.cst.org.documents_diversity.text.htm [2000, March 13].

Love, M. B., Gardner, K., & Legion, V. (1997). Community Health Workers: Who They Are and What They Do. Health Education & Behavior, 24(4), 510-523.

Macaulay, A. C.,, Freeman, W., Gibson, N., McCabe, M. L., Robbins, C., & Twohig, P. (1999). Participatory research maximizes community and lay involvement. British Medical Journal, 3(9), 774-778.

Mackey, J., & Baron, V. (1997-1998). Personal Story: Exploring the Needs of Immigrants and Refugees in Canada. Vol. 12(3/4). Edmonton, Alberta: Newsletter of Canadian Council on Multicultural Health.

MacKinnon, M., & Howard, L. l. (2000). Affirming Immigrant Women's Health: Building Inclusive Health Policy. Halifax, Nova Scotia: Maritime Centre of Excellence for Women's Health.

Mallory, C. (2001). Examining the Differences between Researcher and Participants: An

Intrinsic Element of Grounded Theory. In R. S. Schreiber, & P. N. Stern (Eds.), Using Grounded Theory in Nursing (pp. 85-96). New York: Springer Publishing Company.

Masi, R., Mensah, L., & McCleod, K. (1999). Health and Culture: Exploring the Relationships. Ontario: Mosaic Press.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. BMJ, 320, 50-52.

McKinlay, J. (1994). A case of refocussing upstream: The political economy of illness. In C. P. Ken. R (Eds.), The Sociology of Health and Illness (pp. 509-521). New York: St. Martin's Press.

McKnight, J. (1993). Politicizing Health Care. In J. McKnight (Ed.), The Careless Society: Community and its Counterfeits (pp. 80-88). New Yorg: Basic Books.

McKnight, J. (1977). The Professional Service Business. Social Policy, 110-115.

McKnight, J. (1989). Do No Harm: Policy Options that Meet Human Needs. Social Policy, 20(1), 5-15.

McKnight, J. (1987). Regenerating Community. FIRST READING, 1-2.

McLeod, B. (1981). The Mediating Person and Cultural Identity. In S. Bochner (Ed.), The Mediating Person: Bridges between Cultures (pp. 37-52). Boston, MA: G.K. Hall and Co.

McNicoll, P. (1999). Issues in Teaching Participatory Action Research. Journal of Social Work Education, 35(1), 51, 12 p.

McWilliam, C. (1997). Using Participatory Research Process to Make a Difference in Policy on Aging. Canadian Journal on Aging, Supplement.

Minkler, M. (1998). Introduction and Overview. Iin M. Minkler (Ed), Community Organizing and Community Organizing for Health . New Jersey: Rutgers University Press.

Mittelmark, M. B. (2000). Technical Report #3. Promoting Social Responsibility for Health: Progress, Unmet Challenges and Prospects. Mexico City: World Health Organization.

Morris, H., Ogilvie, L., Fung, M., Lau, A., Ong, A., & Boyd, J. (1999). Cultural Brokering in Community Health. The Canadian Nurse, 28-32.

Multicultural Health Broker's Co-op. (1998). Mission Statement.

Multicultural Health Brokers Co-operative. (2001). MCHB Report 1999/2001.

Mustard, F. J., & Frank, J. (1991). The Determinants of Health. Toronto: Canadian

Institute for Advanced Research.

Nakhaie, R. M. (1999). Vertical Mosaic among the Elites: The New Imagery Revisited. In M. Reza Nakhaie (Ed.) Debates on Social Inequality: Class, Gender and Ethnicity in Canada (pp. 264-278). Toronto: Harcourt, Brace and Company.

Nasroo, J. (1998). Genetic, Cultural or Socio-Economic Vulnerability? Explaining ethnic inequalities in health. Sociology of Health and Illness, 20(5), 710-730.

Newcomb, T. M. (1956). Social Psychology. New York: Dryden Press.

Nimmagadda, J., & Cowger, C. D. (1999). Cross-cultural practice: Social worker ingenuity in the indigenization of practice knowledge. International Social Work, 42(3), 261-276.

O'Neil, , K. J. M., Kaufert, P. L., & Koolage, W. (1993). Political Considerations in Health-related Participatory Research in Northern Canada. In N. Dyck, & J. B. Waldram (Eds.), Anthropology, Public Policy and Native Peoples in Canada (pp. 215-232). Montreal: Queen's University Press.

Oakeshott, R. (1978). The Case for Worker's Co-ops. London: Routledge & Kegan Paul.

Pagaduan, M., & Ferrer, E. M. (1983). Working as equals - Towards a Community-based evaluation system. Community Development Journal, 18(2), 146-158.

Paine, R. (1971). Theory of Patronage and Brokerage. In R. Paine (Ed.), Patrons and Brokers in the East Arctic . Toronto: University of Toronto .

Parhar, A. (1999). Social Justice and the Canadian Context: A review of the literature. Ottawa: Department of Canadian Heritage.

People's Republic of China. (1977). A Barefoot Doctor's Manual: The American Translation of the Official Chinese Paramedical Manual. Philadelphia, Pennsylvania: Running Press.

Phinney, J. S. (1996). When We Talk About American Ethnic Groups, What Do We Mean? American Psychologist, 51(9), 918-927.

Pilisuk, M., McAllister, J., & Rothman, J. (1998). Social Change Professionals and Grassroots Organizing: Functions and Dilemma. In M. Minkler (Ed.), Community Organizing and Community Building for Health. New Jersey: Rutgers University Press.

Plaut, T., & Landis, S. (1992). Enhancing Participatory Research with the Community Oriented Primary Care Model: A Case Study in Community Mobilization. American Sociologist, 23(4), 56-71.

Poland, B. (1996). Knowledge development and evaluation in, of, and for Healthy Community Initiaves. Part I: guiding principles. Health Promotion International,

11(3), 237-247.

Polk, M. (1995). Feminism and Human Ecology. In Human Ecology: Progress through Integrative Perspectives Michigan: The Society for Human Ecology.

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. British Medical Journal, 320, 114-116.

Population and Public Health Branch, A. R. H. C. (Poverty as Social and Economic Exclusion [Web Page]. [2001, August 8].

Press, I. (1969). Ambiguity and Innovation: Implications for the Genesis of the Culture Broker. American Anthropologist, 71.

Procidano, M. E., & Heller, L. (1983). Measures of perceived social support from friends and from family: three validation studies. Journal of Community Psychology, 11, 1024.

Quarter, J. (1992). Canada's Social Economy: Cooperatives, Non-profits and other Community Enterprises. Toronto: James Lorimer & Company.

Rains, J. W., & Wiles, D. R. (1995). Participatory Action Research for Community Health Promotion. Public Health Nursing, 12(4), 256-261.

Ramirez-Valles, J. (1999). Changing Women: The Narrative Construction of Personal Change Through Community Health Work among Women in Mexico. Health Education & Behavior, 26(1), 25-43.

Ramontja, R. M., Wagstaff, L. A., & Khomo, N. E. (1998). Urban Community Health Workers: selection, training, practice and outcome. Curationis, 21(3), 38-41.

Rasmussen, D. (1996). Critical Theory and Philosophy. In D. Rasmussen (Ed.), The Handbook of Critical Theory . Cambridge, Massachusetts: Blackwell Publishers, Inc.

Ratcliffe, J. W., & Gonzales-del-Valle, A. (1988). Rigor in Health-Related Research: Towards an Expanded Conceptualization. International Journal of Health Services, 18(3), 361-389.

Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. (1988). Health and Welfare Canada.

Restreppo, H. (2000). Technical Report #4. Increasing Community Capacity and Empowering Communities for Health. Mexico City: World Health Organization.

Ricks, F., Charlesworth, J., Bellefeuille, G., & Fiekd, A. (1999). All Together Now: Creating a Social Capital Mosaic. Victoria: Vanier Family Institute.

Rita Schreiber. (2000). Grounded Theory Workshop Notes.

Rivera, F., & Erlich, J. (1995). Community Organizing in a Diverse Society. Boston: Allyn and Bacon.

Robrecht, L. (1995). Grounded Theory: Evolving Methods. Qualitative Health Research, 5(2), 169-177.

Roman, L. A., Lindsay, J. K., Moore, J. S., & Shoemaker, A. L. (1999). Community Health Workers: Examining the Helper Therapy Principle. Public Health Nursing, 16(2), 87-95.

Rootman, I., & Raeburn, J. (1994). The Concept of Health. In A. Pederson, M. O'Neill, & I. Rootman (Eds.), Health Promotion in Canada: Provincial, National and International Perspectives (pp. 56-71). Toronto: W.B. Saunders of Canada.

Sanders, D., & Carver, R. (1995). The Struggle for Health: Medicine and the Politics of Underdevelopment. London: McMillan Education Ltd.

Schreiber, R. S. (2001). The "How To" of Grounded Theory: Avoiding the Pitfalls. in R. S. Schreiber, & P. N. Stern (Eds.), Using Grounded Theory in Nursing (pp. 55-84). New York: Springer Publishing Company.

Schultz, A., Israel, B., Becker, A. B., & Hollis, R. M. (1997). It's a 24-hour thing...living for-each-other concept: Identity, Networks, and Community in an Urban Village Health Worker Project. Health Education & Behavior, 24(4), 465-481.

Scupin, R. (1998). Cultural Anthropology: A Global Perspective. New Jersey: Prentice-Hall.

Sharma, S. (1988). Bridging the Gap: Anthropological Brokerage in Nursing Care. Dissertation.

Sharp, P. C., Dignan, M. B., Blinson, K., Konen, J. C., McQuellon, R., Michielutte, R., Cummings, L., Hinojosa, L., & Ledford, V. (1998). Working with lay health educators in a rural cancer-prevention program. American Journal of Health Behavior, 22(1), 18-27.

Shumaker, S. A., & Brownell, A. (1984). Toward a theory of social support: closing conceptual gaps. Journal of Social Issues, 40, 11-36.

Sidebotham, P. D. (1998). Community child health in Cambodia: an evaluation of two programmes...including commentary by Mollica R, and Moghtader L. Ambulatory Child Health, 4(2), 223-230.

Sidebothanm, P. F. D. (1998). Community Child Health in Cambodia: an evaluation of two programs. Ambulatory Child Health, 4(2), 223-230.

Smaje, C. (1996). The Ethnic Patterning of Disease: New Directions for Theory and Research. Sociology of Health and Illness, 18(2), 137-171.

Smith, S. (1997). Deepening Participatory Action Research. S. E. Smith, D. G. Willms, & N. Johnson (Eds.), Nurtured by Knowledge: Learning to Do Participatory Action-Research (pp. 173-264). New York: Apex Press.

Sohng, S. L. (1995) Participatory Research and Community Organizing [Web Page]. URL http://www.interweb-tech.com/nsmet/docs/sohng.htm [2000, January].

Starfield, B. (2000). Equity in Health. CMAJ, 162(3), 346-47.

Statistics Canada. (1996) Population Statistics for Edmonton, Alberta [Web Page]. URL http://ww2.statscan.ca/english/profil/ [1999].

Statistics Canada. (1996 Population Statistics [Web Page]. URL http://ww2.statcan.ca/english/profil/ [2000, February 14].

Statistics Canada. (URL www12.statcan.ca/english/census01/ [2003, January 29].

Stephens, T. (1998). Ottawa: Mental Health Promotion Unit, Health Canada.

Stephenson, P. H. (1995). Vietnamese Refugees in Victoria, B.C.: An Overview of immigrant and refugee health care in a medium sized urban centre. Social Science and Medicine, 40(12), 1631-1642.

Swidinsky, R. (1997). White Visible Minority Earning Differentials: A Comparison of Immigrant and Native-born Canadians. Richmond, BC.

Sykes, B., Wolfe, R., Gendreau, L., & Workman, L. (May,1997). "Naming the Practice of Cultural Brokering": Culturally Responsive Perinatal Health and Family Support Project.

Szasz, M. C. (1994). Introduction. In M. C. Szasz ((Ed), Between Indian and White Worlds: The Cultural Broker (pp. 4-19). Norman & London: University of Oklahoma Press.

Taffesse, M. (1999). The Politics of Access and Racism: The twin challenges to Canadian multiculturalism. In A. Richardson (Ed.), International Multiculturalism 1998: Preparing together for the 21st century (pp. 491-501). Edmonton, Alberta: Kanata Learning Co.

Taft, R. (1981). The Role and Personality of the Mediator. In S. Bochener (Ed.), The Mediating Person: Bridges between Culture (pp. 53-87). Boston, MA: G.K. Hall and Co.

Taylor, C. E. (1992). Surveillance for Equity in Primary Health Care: Policy Implications from International Experience. International Journal of Epidemiology, 21(6), 1043-1049.

Tesh, S. (1988). Hidden arguments: political ideology and disease prevention. New Brunswick, NJ: Rutgers University Press.

Townsend, P., & Davidon, N. (1992). Inequalities in Health. Harmondsworth: Penguin.

Tripp-Reimer, T., & Brink, P. J. (1985). Cultural Brokerage. In G. M. Bulechek, & J. C. McCloskey (Eds.), Nursing Interventions: Treatment for Nursing Diagnoses (pp. 352-364). Philadelphia: W.B. Saunders.

Tseelon, E. (1991). The Method is the Message: On the Meaning of Methods as Ideologies. Theory and Psychology, 1(3), 299-316.

van den Hoonard, W. C. (1997). Working with Sensitizing Concepts: Analytical Field Research. Thousand Oaks: Sage Publication.

Waldram, J. B., Herring, D. A., & Kue Young, T. (1995). Aboriginal Health in Canada: Historical, cultural, and epidemiological perspectives. Toronto: University of Toronto Press.

Weber, M. (1968). Economy and Society Vol. 1. New York: Bedsminter.

Weidman, H. H. (1982). Research Strategies, Structural Alterations and Clinically Applied Anthopology. In N. J. Chrisman, & T. W. Maretski (Eds.), Clinically Applied Anthropology: Anthropologists in Health Science Settings (pp. 201-241). Amsterdam: D. Reidel Publishing Company.

Weijer, C. (1999). Protecting Communities in Research: Philosophical and Pragmatic Challenges. Cambridge Quarterky of Healthcare Ethics, 8, 501-513.

Weijer, C., Goldsand, G., & Emanuel, E. J. (1999). Protecting communities in research: current guidelines and limits of extrapolation. Nature Genetics, 23, 275-280.

Wilkinson, R. (1996). Unhealthy Societies: The afflictions of inequality. New York: Routledge.

Wilkinson, R. (2001). Mind the Gap: Hierarchies, Health and Human Evolution. New Haven: Yale University Press.

Wilkinson, R., & Marmot, M. (1998). The Solid Facts: The Social Determinants of Health. Denmark: Centre for Urban Health, World Health Organization.

Witmer, A., Seifer, S., Finocchio, L., Leslie, & O'Neil, E. (1995). Community Health Workers: Integral Members of the Health Care Work Force. American Journal of Public Health, 85(8), 1055-1057.

Wolf, E. (1956). Aspects of group relations in a complex society: Mexico. American Anthropologist, 56, 1065-1078.

Wolfe-Gordon Consulting. (1998). Final Evaluation Report on the Culturally Responsive Perinatal and Family Support Project: Summary Learning with Discussion p. 1-32.

World Health Organization. (1987). The community health worker: working guide: guidelines for training. Geneva, Switzerland: World Health Organizations Publications.

World Health Organization Regional Office for Europe. (1985). Primary Health Care in Industrialized Countries. Copenhagen, Denmark: World Health Organization.

Wuest, J. (1995). Feminist Grounded Theory: An Exploration of the Congruency and Tensions Between Two Traditions in Knowledge Discovery. Qualitative Health Research, 5(1), 125-137.

Young, D. E., Spitzer, D. L., & Pang, F. (1999). Understanding the Health Care Needs of Canadian Immigrants. Edmonton. Alberta, Canada.

Zakus, J. L. (1998). Resource dependency and community participation in primary health care. Social Science and Medicine, 46(4-5), 475-494.

Ziglio, E., Hagard, S., McMahon, L., Harvey, S., & Levin, L. (2000). Technical Report 2: Investment for Health. Fifth Global Conference on Health Promotion: Bridging the Equity Gap. Mexico City: World Health Organization.

APPENDIX A

CONSENT FORM

MULTICULTURAL HEALTH BROKERING: Bridging cultures to achieve equity of access to health

CONSENT FORM

This consent form is our mutual agreement about your participation in the study. We both agree to abide by the ethical principles in this research that was developed jointly by the MCHB Coop members and the investigators as attached in this form.

Before you answer the questions below, please read and discuss with the interviewer the Information Sheet about this research. Please feel free to ask questions about this study. This set of questions below is our guide in determining whether the interviewer has thoroughly explained what the study is all about and what it means to participate in it.

Please circle your answers.

1. Do you understand that you have been asked to be in a research study?	Yes	No
2. Have you read and received a copy of the attached Information sheet?	Yes	No
3. Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
4. Have you had the opportunity to ask questions and discuss the study?	Yes	No
5. Do you understand that you can quit taking part in this study at anytime? You do not have to say why.	Yes	No
6. Has confidentiality been explained to you?	Yes	No
7. Do you understand who will be able to see or hear what you said?	Yes	No
8. Do you understand that other MCHBs may know that you have participated in this study but they will not know what you said?	Yes	No
9. Do you know what information you say will be used for ?	Yes	No
10. Do you agree to have your interview tape recorded?	Yes	No

I discussed this study with _____.

I agree to take part in this study and consent to the use of the data as stated in the purpose of the study. I also understand that I am not to disclose any specific information about my clients with respect to names, addresses, details of medical or health issues, personal health insurance number and other personal information that will identify a specific person pursuant to the Health Information Act.

_____ _____

Signature of Research Participant Date

_____

Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate and consent to the use of the data as stated in the purpose of the study. She/he also understands the provisions of the Health Information Act in the collection, use and disclosure of information as attached in this Consent Form.

_____

Signature of Investigator

Copy of the Report:

Would you like to receive a short version of report? Yes No

If you would like a copy of the report, please write the address below where we can send you a copy.

_____

_____

Acknowledgement:

This consent form was based largely on the sample consent form attached to the Application Information for Human Research Ethics Board, Faculty of Agriculture, Forestry and Home Economics.

APPENDIX B

INFORMATION SHEET

INFORMATION SHEET

(What you need to know about this study)

Multicultural health brokering: bridging cultures to achieve equity of access to health

1. What is the purpose of this study

   The study will help you to describe and define your cultural brokering practice based on your own experience and reflections. Since you have been doing this kind of work since 1993, this is an opportunity for you to step back and reflect on what you have accomplished, your difficulties and your vision for the future.

2. What kind of information will be collected in this study

   The study will ask you primarily about your experience as Multicultural Health Broker – how you describe your work, the circumstances of families and communities you have served, ways of helping them, problems and difficulties you encountered. You will also be ask some personal questions such as your country of origin, your experience as a newcomer, why you became a Multicultural Health Broker.

3. How will the information be collected

   Personal interviews with the Multicultural Health Brokers, such as yourself will be done at your time and place of convenience. The interviews will last about two hours. Your interview will be recorded on tape. You will also be asked to participate in a focus group at a later stage to discuss about the findings of the study and what you think about it.

4. Will I be identified in the study

   Your name will not be recorded in the tape. We will either use a number or fake name to identify your interview. Any information that has your name will be kept in a locked cabinet at the University of Alberta. It is possible that the MCHB Coop will know that you

participated in the study but they will not know what you said. Only the principal and co-investigators will know your name.

5. Can I have access to my taped interview

   Your taped interview will be available for you when you want to listen to it. You will be given a copy of the transcribed interview for you to review for accuracy.

6. What will I get out of the study

   As we have agreed when we planned this study together, your participation in the study will have direct benefits for you as a worker and for your organization. As a practitioner, this is an opportunity for you to collect what you have learned from your eight years of practice as an MCHB. The clarity of your work that you will have gain from this research will help people to understand better what your role is and what your work involves. As an organization, it will be chance for the COOP to work towards a formal recognition of the MCHB practices as well as your contribution in improving the health of your community.

7. Will the study cause harmful or negative effects

   The study is not expected to harm any one who is involved in the research. It is possible that when you relate some of your personal experience, it might upset you or cause some bad feeling. We will do our best to respond to these feelings and see to it that you get the appropriate help.

8. What if I decide not to participate

   You have the right to withdraw from the research any time you wish before, during and after the interview. Your data will not be used in the research if you have decided not to participate in the study.

9. What will you do with the results of the study

The results of the study will be discussed with you once the data are organized for analysis. In fact, you will participate in the analysis and interpretation of the data because your ideas, thoughts and feelings are valuable throughout the research. A research report will be given to you once it is completed.

This research is also done as part of doctoral dissertation. It will be submitted to the University of Alberta as part of a requirement for a degree. But the person who will determine the best use of the results of the study will be you as well as other research participants.

THANK YOU VERY MUCH!

APPENDIX C

INTERVIEW GUIDE

University of Alberta
Department of Human Ecology

Multicultural Health Brokering: Bridging cultures to achieve equity of access to health

Participant ID No. _____

Interview Information:

Name: _____ Gender: _____

Address: _____

Telephone: _____

Date of Interview: _____ Place of Interview:_____

Time Started: _____ Time Finished:_____

Language of Interview: _____

Personal Information:

1. What is your country of birth?
2. What did you do in your home country?
3. When did you come to Canada?
4. How did you come to Canada? What made you come to Canada?
5. How do you like this country? And Edmonton?
6. Do you have a family here? Who are with you in Edmonton?
7. How does your family/children like it here?
8. Did you have other job/work before you were a MCHB? What was/were this/these job/s?
9. When did you start as a MCHB? How did you start as an MCHB?

The information we want to collect	The questions we had suggested
Description of the actual practice (How did we actually do cultural brokering) 1. Initiation (circumstances when MCHB was first contacted)	1. Can you describe who are your clients? 2. How do they contact you? 3. Why do they usually contact you? Is there any specific reason why they contact you? Under what situation or circumstances would you be contacted?
2. Setting of cultural brokering practice	4. Where do you usually meet with your clients?
3. Clients circumstances, issues, problems	5. How do you usually introduce yourself as a multicultural health broker? 6. What kinds of issues/ problems do your clients present to you?
4. Interventions & strategies to address client's needs, issues, problems	7. What do you see your role in addressing client's needs, issues and problems?> 8. How do you help clients in solving their problems? Empower them? 9. How do you keep yourself from being emotionally involved with your clients? How do you control your feelings and emotions?
5. Length of involvement of MCHB with client	10. When do you let go? What conditions or circumstances will tell you that it's time to let go? Average length of time of involvement? 11. Were you ever in a situation where you had conflict with your client?
6. Outcomes and results of interventions	12. What do you expect as a result of your interventions? 13. What frustrates you in your work as a multicultural health broker? 14. What was the most difficult part of the work? 15. What was the most rewarding or joyful moment?

The information we want to collect	The questions we had suggested
B. Cultural brokering as a formal practice 1. Knowledge and skills	**(Elements of an effective practice based on experience)** 11. How would you describe the cultural brokering practice? 12. What information do you use the most when working with families? 13. What skills does a cultural broker need?
2. Personal qualities	14. What personal qualities does a cultural broker need to be effective in her work? 15. What personal qualities do you have that helped you the most in your work?
3. Challenges to personal growth and career development	16. Have you observed changes in you as a person since you have started this work? 17. What would make a good and effective multicultural health broker?
C. Thoughts on the future	
1. Role of other organizations in supporting MCHB	18. What kind of support did the MCHB/s receive from these agencies or groups? 19. Were they any changes in these agencies or groups in their service delivery as a result of your work with them?
2. Role of MCHB Coop	20. How does the Coop support the MCHBs in their work? What kind of support does the MCHB need to provide better services? 21. What changes have you experienced as a result of being a member of the Coop?
3. Challenges to sustaining the MCHB practice	22. Do you think the practice of multicultural health brokering will continue in the future? Why?
4. Challenges to sustaining the MCHB Coop	23. What frustrates you about the Coop? What worries you about the Coop? 24. What do you see as the Coop's most difficult task as an organization 25. What changes do you want to see in the Coop in the future? 26. What advice would you give to someone who wants to be a multicultural health broker?

APPENDIX D

INVITATION TO FIRST FOCUS GROUP

November 19, 2001

Dear

I am pleased to give you a copy of the transcript of your interview. Please feel free to examine the transcript for its content and accuracy. I have tried to transcribe your interview to the best of my ability but then an amateur interviewer like me can sometimes make mistake or may have not heard you very well. I apologize for statements that may have been omitted or misheard. Please let me know if there portions in your interview that needed to be corrected.

This transcript is very valuable for both of us because it represents your thoughts and sentiments about something that we all care to discover: the multicultural health brokering practice. We will use this transcript in our focus group workshop on November 21, 2001 at 12:00 noon at the Pine Room at Plaza 124. The focus group workshop is an opportunity for us to do a collective analysis of our own data. Specifically, we will generate themes from our own experience of cultural brokering which shall become the basis for a formal description of our practice.

In this workshop we will only work on some specific aspect of your interviews. These sections are marked with a highlighter. So In preparation for this session, here are some suggested things you might want to do in advance:

- Study the highlighted sections in your interview
- Identify some key words from the highlighted sections that describes your work
- Write them down at the right most margins of your interview

Please do not forget to bring your transcripts to the focus group session.

Again, my heartfelt thanks for your interest and participation in the interviews and the focus group. I look forward to seeing all of you on Wednesday, November 21 at the Plaza.

Warmest regards,

Lucenia

APPENDIX E

LIST OF OPEN CODES

Focus Group Results – Phase 1 MCHB Participants
November 21, 2001

Key Words	Themes/Description
1. Listen	• Learn/discover something • Clarify what client is saying • Put yourself in the situation • Person is important • Take time to understand issues/circumstances • Relieve client of their load and issues
2. Home visiting	• Being visible to the client • Put a face to the "service" • On client's turf • See all facts together • Mirror for them to look at themselves • See the whole picture • Make it easier for client • More comfortable place to learn • Indication of trust • Home setting allows more opportunity for learning • Clients do a better job of learning • Client feel important and cared for • Two-way learning mirror
3. Explain, discuss	• Client knows what to expect from the health system • Service providers learn about client's situation and needs
4. Analyze; rephrase; adapt to situation	• Work through with the client issues and problems in their own way • Talk it out, organize their thoughts and find ways to solve problem by themselves
5. Help; providing help; assist	• Get yourself involved • Information giving; participatory process "coaching" • Problem-solve • Mapping out problems and issues • Encourage clients to so things by themselves
6. Sharing/presenting information; provide information; information dissemination;	• Explain "technical" health information • Raise information awareness about it relates to their issues • Information according to their needs • Both ways from clients; 2 – way info giving • Implies power differential (MCHB – giver; client

giving time to understand information	• – recipient) • Relevant and appropriate • Info about client; cultural knowledge to service providers
7. Refer; connect	• Connecting community with system • Realize that client needs services outside of MCHB capacities • Open opportunities for clients
	• Referrals to MCHBs from service providers • Able to serve clients needs • Unique services – follow-up and language and cultural sensitivity
8. Work together	• With service providers to help with issues of clients • With family members to solve problems and issues • With other MCHBs "sisterhood"
9. Parenting	• Teaching parents to compromise • Cross-cultural understanding of parenting issues • Enhancing communication between generations
10. Advocate	• Speak on behalf of clients • Act on their behalf • Give them most benefits from the system • Address equity • Level the situation • Encourage client to do better • Share clients knowledge of others • Work for rights of the community
11. Networking; partnering	• Give and take • Collaborating on similar goals • Connecting clients with community members • Working with other professionals • Become more resourceful
12. Building community	• Connecting clients to community • Empowering; self-reliant • Developing their own strength
13. Support	• All of the above • Be honest; understanding co-worker • To do with resources and capacities • Being with the people in times of crises • "should we put ourselves at risk" • different kinds of crisis and distress

Other key words not discussed:

- Conducting classes/Learning/adult learning
- Language and culture
- Helping to access; able to ask for help
- Promoting our services
- Focusing in
- Organize
- Drive
- Finding best approach
- Empower/empowering
- Get call/contact
- Connected
- Comfortable
- Outcome
- Ongoing resources
- Introducing
- Facilitating
- Normalize; naturalize

APPENDIX F

INVITATION TO SECOND FOCUS GROUP

Whatever happened to the MCHB Research: An invitation to see a glimpse of the result of interviews

If you are interested ……..

- **To see the information we have gathered from our interviews**
- **To put in your own thoughts about what this information mean to you**
- **Be part of the exciting team to work on the definition of the MCHB practice**

Then come and be with us on ……..

Friday, February 8 from 12:00 noon – 5:00 p.m
MCHB Coop Office

Light lunch will be served

APPENDIX G

LIST OF CLUSTERED OPEN CODES AND PRELIMINARY THEMES

Open Codes 1

- "Being there"
- "Putting ourselves at risk"
- Gain confidence of clients
- Normalizing the situation
- "Being there as a friend"; "sister", "aunt", "mother"
- Providing a safe place to talk and share

Preliminary themes: building relationships with clients; support; instant rapport

Open Codes 2

- Listening with depth
- Mirroring; clarifying what client is saying
- Keenly observing
- Putting yourself in the situation
- Take time to understand issues
- Relieve client of their load and issues
- Establishing the client's context

Preliminary themes: empathy; reflective listening; authenticating

Open Codes 3

- Analyze
- Work through with clients their issues and problems
- See the whole picture
- Mapping out problems and issues
- Talk it out
- Coaching
- Focusing in
- Revealing multi-layered problem
- See all facts together

Preliminary themes: explaining cultural differences; critical and holistic analysis; cultural assessment; collaborative problem solving

Open Codes 4

- Explain to client what to expect about the health system
- Bridging cultural issues
- Discuss with service provider about clients' situation and needs
- Share "technical" health information
- Explain cultural knowledge to health providers

- Education
- Sharing experiential knowledge
- Teaching

Preliminary themes: bridging understanding of different perspectives; facilitating; enhancing knowledge of clients

Open Codes 5

- Facilitating (making it easier to understand)
- Exploring options
- Counselling
- Referring clients to right resources
- Accessing resources for clients
- Connecting clients to resources and community
- Finding best approach

Preliminary themes: linking resources to clients; creating opportunities to access services; navigating the system

Open Codes 6

- Networking with service providers and agencies
- Partnering with service providers and agencies
- Collaborating with groups and communities

Preliminary themes: complementing; building complementary relationships; socially connecting

Open Code 7

- Advocating
- Level the situation/address equity
- Act on behalf of the clients
- Speak on behalf of the clients
- Increase people's access to services
- Advocating within the system

Preliminary themes: advocating; achieving equity; empowering

Open Codes 8 Multiple themes

- Mediating with a strong emphasis on the disadvantaged
- Bridging two unequal realities
- Changing policy and systems

- Articulating issues of the marginalized
- Empowering
- Developing own (client's) strength
- Building capacities
- Building groups
- Organizing groups
- Building communities
- Organizing communities

Preliminary themes: building resilient communities; systems change; structural advocacy; building cohesive groups

Preliminary patterns and relationship of clustered codes

- Process, stages or phases
- Dimensions or different spheres of activities

Source:

Focus group discussion: February 8, 2002

APPENDIX H

AGENDA OF VALIDATION WORKSHOP

MCHB Research Validation Workshop
March 4, 2002
4:30 - 6:00 p.m.
Coop Office

What's happening today?

1. MCHB Research Refresher and Overview of Grounded Theory

2. What information do we have and how do we want to use it

3. Examining our data

   - Developing concepts about multicultural health brokering

   - What makes an effective multicultural health broker

     - (Knowledge, skills, personal qualities and coping with frustrations and challenges)

     - The essential qualities: towards a framework of competency for MCHBs

   - The Coop Experience

     - Positive changes as a result of being a member
     - Our most difficult task
     - Changes we want to see in the Coop

What information do we have and how do we want to use them

Information generated	How will it be used in the research
1. Profile and background of MCHBs (Immigration history, employment experience in Canada, history of MCHB work)	To describe the context and circumstances of multicultural health brokers
2. Description of the actual practice (Initiation, presenting issues, interventions and outcomes)	Develop concept/concepts of multicultural health brokering and come up with a definition
3. Multicultural health brokering as a formal practice (Knowledge, skills, personal qualities and coping with frustrations and challenges)	To identify the essential qualities and develop a framework for competency
4. The Coop Experience (Positive changes as a result of being a member; Our most difficult task; Changes we want to see in the Coop)	To identify our organizational strengths; strategic directions; and operational support to members